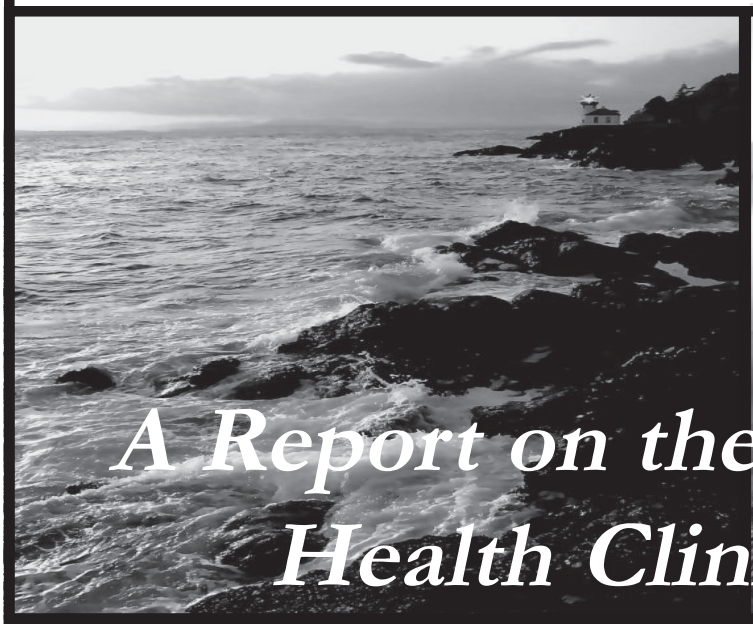
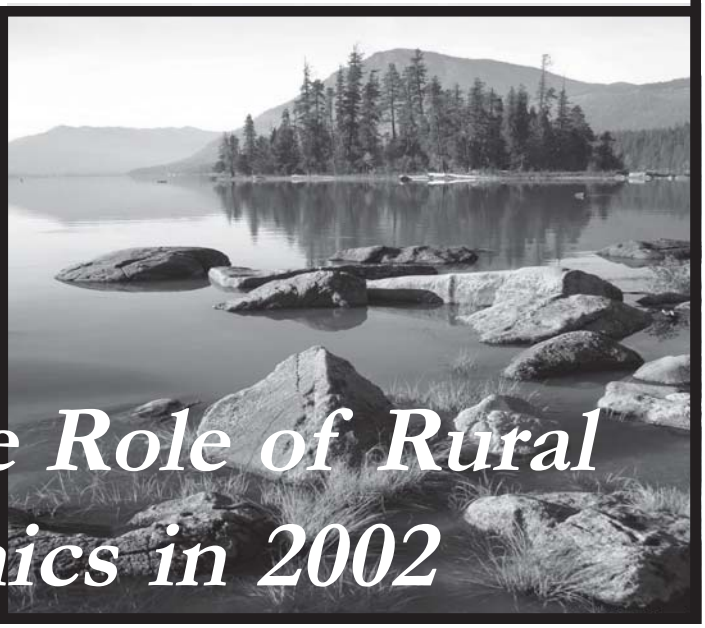
Rural Health Clinics in Washington State





A Report on the Role of Rural Health Clinics in 2002

Rural Health Clinic Final Report

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Oregon's Rural Health Clinics

Diane Redd, Oregon Primary Care Association, January 2001

The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook

John A. Gale and Andrew F. Coburn, Edmund S. Muskie School of Public Service, University of Southern Maine, January, 2003

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Contents

Executive Summary

This report covers three surveys of the Rural Health Clinics in Washington State and the RHCs role in the health care of Medicaid, Medicare and uninsured populations as part of the rural health care safety net.

Background

In 2002, the Office of Community and Rural Health (OCRH) in Washington State's Department of Health brought together concerned stakeholders to begin a process of gathering data about the utilization of the state's then 102 federally designated Rural Health Clinics (RHCs) (Appendix A – Overall Study Methodology). Stakeholders included the Rural Health Clinic Association of Washington, the Washington State Hospital Association Rural Committee, the Washington State Medical Association, the Association of Washington Public Hospital Districts, the Eastern and Western Washington Area Health Education Centers as well as OCRH staff.

Methodology

Quantitative Survey: OCRH contracted with East West Consulting, a private consulting firm in Bellingham, Washington to do a quantitative analysis of the RHCs, assessing the overall financial health of RHCs and the degree to which RHC status contributed to their financial success or failure. The survey was designed to permit a comparison of the state's RHCs to primary care medical clinics in general and to allow clinics to compare themselves individually to a variety of benchmarks. The financial data and productivity results provide data about the clinic chart of accounts and key variables in the Medicare cost reports. The mailed financial survey had a 42% return rate, equally distributed between the east and west sides of the state.

Qualitative Survey: OCRH also contracted with Washington State's two Area Health Education Centers (Eastern Washington Area Health Education Center, Washington State University Extension in Spokane and Western Washington Area Health Education Center in Seattle) to develop and perform a qualitative survey of the clinics. During the summer of 2003, *88 of the 102 clinics* agreed to be visited by AHEC staff. At most of the clinics, the administrator and at least one physician and one mid-level practitioner were interviewed. The RHCs surveyed were equally distributed between the east and west sides of the state.

Observational Survey: During visits to the RHCs, AHEC staff also did an observational, subjective survey of each clinic site.

The Rural Health Clinic Association of Washington (RHCAW) was consulted on the development of the survey tools and encouraged all their members to participate. OCRH provided funds for the RHCAW to provide financial incentives to the clinics which participated by covering their dues payment for membership in RHCAW for the following year.

Conclusions

Analysis of the data received through both the quantitative and qualitative surveys clearly shows evidence that Washington's Rural Health Clinics are serving the public purpose of serving Medicare, Medicaid and uncompensated patients for which the program's financial incentives are designed. Eighteen percent (18%) of all RHC clinics visits are Medicaid compared to only 5% for other Washington Family Practices. Medicare visits were 25% compared to 19.48% in RHCs nationally.

For the purpose of analysis, the data was analyzed by three types of independent variables: Type of RHC designation (Hospital-Affiliated or Non-Hospital-Affiliated); Geographic location (isolated, small town, large town); and Clinic size (2 or < physicians, 3-5 physicians and >5 physicians). The contractors also looked at whether the length of time the clinic had been a RHC influenced access.

In general, the median medical revenue per visit was below the national average ($87.88 vs $95.99); the operating costs per visit were lower ($49.70 vs $63.80); total physician costs/physician are lower that the US median ($176.361 vs $180,728), but higher than the Washington median ($145,798). There is a tremendous variation in income between the clinics, which overall had a net positive income (range from a loss of $2 million to a gain of $2 million). Forty-two percent (42%) of the reporting clinics had an operating loss in 2002.

Utilization and productivity of the RHCs measured by physician visits (median per FTE physician was 5,126 visits) annually compares favorably to the US median of 4,215 and Washington median of 4,001. Washington RHCs make much more extensive use of mid-levels than typical primary care physicians. There are .74 mid-levels for every physician FTE compared to .45 in non-RHC practices. The RHCs are highly productive, largely due to the extensive use of mid-levels.

Due to larger market areas, the RHCs located in large towns had an average of 20,157 patients visits compared to 8,829 visits in small town clinics and 6,834 in isolated clinics. RHC clinic Medicare percentages are inversely proportionate to the population base in their area with isolated clinics seeing 31% Medicare, small town clinics seeing 24% and large towns 14%.

The number of years that a clinic had had a Rural Health Clinic designation ranged from 29 years to less than one year. Eighty percent (80%) had been operating as a designated clinic for three years and more. Hospital-Affiliated clinics are 55% of the total clinics.

Not surprisingly, isolated RHCs had the smallest average number of doctors (1) and large towns had over four times as many doctors (6.4 FTE) as small town RHCs (1.2 FTE). The larger clinics were able to be open slightly more hours per day than the smaller ones (9.6 vs 8.4 hours).

The majority of the RHCs offer basic medical services. Less than half of the clinics offer obstetrical services. Most specialty care was referred out, although some of the clinics provide space to visiting specialists. Most common visiting specialists were podiatrists, cardiologists and orthopedists.

RHCs in Washington tend to have fewer clinical and non-clinical support staff than US family practice clinics.

All of the RHC physicians in small towns had hospital admitting privileges; 94% of those in large towns and 83% isolated areas had admitting privileges at the local hospital. Mid-levels practitioners in large towns were unlikely to have admitting privileges (9%). Almost half of the mid-levels in small towns (47%) and a little more than a third in isolated communities had privileges.

Recruitment for providers was more difficult for Non-Hospital-Affiliated RHCs and took longer to fill vacant positions. However, the average length of service for clinicians was over seven years at Hospital-Affiliated clinics and over eleven years at Non-Hospital- Affiliated which tend to be physician owned.

Preparation of clinic administrators for their positions ranged from on-the-job training for someone with a clinical background to degrees in health administration. Formal administrative education was more commonly seen at larger clinics and those that were Hospital-Affiliated.

All of the RHCs have some computer equipment, but the connectivity and usage of it varied widely. There were few clinics with electronic medical records in place, with almost all of them following market developments carefully. There was little commonality with practice management software. Scheduler programs were most often cited as a need along with the caveat that “programs designed for hospital use do not work well for clinics.”

Taken in total, the findings support the hypothesis that the smaller the community, the more difficult it is to operate an RHC. Smaller communities tended disproportionately to require operating subsidies and had a more difficult time generating higher revenues per visit. This is likely due mainly to the lower volumes of visits.

Survey results show that RHC certification in Washington state has increased access significantly for Medicare and Medicaid recipients and that the enhanced reimbursement has enabled RHCs to maintain or increase access for those patients who are uninsured.

Introduction

Healthcare delivery systems in rural Washington state have been affected by several changes over the past decade: reduction in federal reimbursement, revenue loss due to reduced admissions, increased non-compensated (charity) care, and more recently, major increases in medical liability insurance premiums for physicians and hospitals. As a result, since the mid-nineties communities dramatically increased their use of the Rural Health Clinic (RHC) Act as a mechanism to address these changes and stabilize systems. Though the RHC Act has been in place since 1977, until recently Washington state clinics have been slower to convert to its cost-based reimbursement mechanism than many parts of the country (Appendix C: Rural Health Clinic map). As of fall 2003, 26 years after the implementation of the Act, 102 clinics in Washington state have been designated—a 78% rate of growth since 1995.

In order to better understand the role of the RHCs in rural communities and to develop appropriate support services, the Office of Community and Rural Health within the Washington State Department of Health convened concerned stakeholders and developed a process to gather current data on Rural Health Clinics in Washington state. Stakeholders included:

- the Rural Health Clinic Association of Washington,
- the Washington State Hospital Association,
- the Washington State Medical Association, and
- the Association of Washington Public Hospital Districts.

The Office of Community and Rural Health contracted with the following entities to design and write the report:

- the Eastern Washington Area Health Education Center (EWAHEC) at Washington State University Spokane,
- the Western Washington Area Health Education Center (WWAHEC) based in Seattle, and
- East West Consulting, a private consulting firm out of Bellingham, Washington.

This process began in late 2002, with the quantitative and qualitative surveys completed by Rural Health Clinics by fall 2003. Preliminary project results were presented at regional and national rural health conferences in spring 2004, with a final report published in summer 2005. The purpose of this project was to critically analyze the results to determine clinic sustainability, best practices, technical assistance and education needs as well as to identify problems that deter clinic sustainability and profitability. These results will be used to assist in providing targeted technical assistance and educational programs and in advocacy with policymakers.

Healthcare in Rural Washington

Characteristics of Rural Washington

Washington state lies in the far northwest corner of the contiguous United States. Divided east-west by the Cascade Mountains, Washington's climate, demography and geography are highly influenced by this mountain range. To the west are inlets of the Pacific Ocean, rivers draining into the ocean, heavier rainfall and lush vegetation. To the east, the climate is warmer and drier. Much of the area drains into the Columbia River and its tributaries. Slightly more than three-quarters of the population lives in western Washington, primarily along the Interstate-5 corridor and the Seattle-Tacoma-Everett metropolitan area. But urbanized and rural areas are found throughout the state. In fact, nearly half of all Rural Health Clinics are in western Washington.

Not all of rural Washington is the same. The Rural Urban Commuting Area (RUCA) System[1] classifies areas of the state into five general classes:

- Isolated Rural Areas: Areas that do not have a town with a population of 2,500 or more. Ferry County and Republic are examples of this.
- Small Town Areas: Areas with a towns between 2,500 and 9,999 and plus areas that are tightly linked to these communities by commuting patterns. Raymond or Omak are examples.
- Large Town Areas: Areas with a towns between 10,000 and 49,999 and plus areas that are tightly linked to these communities by commuting patterns. Moses Lake and Port Angeles are examples.
- Rural Urban Fringe – The rural areas of urban counties where much of the population commutes to urbanized areas. Examples include Medical Lake outside Spokane and Eatonville outside of Tacoma.
- Urbanized areas.

[1] www.ers.usda.gov/Data/RuralUrbanCommutingAreaCodes.

Table 2-1 RUCA Classes

	Population in 2000	Percent of State Population (%)	Population Growth 1990 – 2000 (%)
Urbanized	4,005,673	68.0	18.4
Rural Urban Fringe	917,894	15.6	46.0
Large Town*	596,499	10.1	22.8
Small Town	291,555	4.9	1.2
Isolated Rural Area	82,500	1.4	1.2

*This includes, Mt. Vernon – Burlington, Wenatchee, and Clarkston which are now classified as Urbanized. The update of the RUCA system that includes newly urbanized areas was not available at the time of writing.

For the purposes of this report, the classifications of Isolated, Small Town and Large Town were used to classify the locations of Rural Health Clinics.

Nonetheless, there are more than one million rural Washingtonians and these residents, on the whole, have different demographics and, in many respects, experience healthcare in different ways. Residents of rural Washington are more likely to be older, to have lower incomes, to be in poverty, and to work in different employment settings. For example, poverty rates were 16% of the population in rural areas but just under 10% in urban areas. While the residents of rural Washington are less likely to be racial or ethnic minorities, the proportion of minorities in rural areas has grown rapidly over the past decade.

East Adams Rural Hospital / Ritzville Medical Clinic

Even within the rural parts of Washington, there is significant variation. Population growth in the most isolated areas has been flat and all the demographic indicators such as income levels, poverty, and unemployment are more adverse. Because of the distinctions between isolated, small town and large town RHCs in terms of demographics, economics, available health resources and other factors, they are studied as distinct groups in this report.

Reflecting the differences described above, health services in rural Washington are also organized differently and, in many ways, are even accessed differently. Rural health systems are highly interdependent and are becoming more so over time[2]. Often the various provider types—hospital, physician, long term care, EMS, pharmacy and so forth—are under common ownership or management. The same physicians may work in each setting and the administrative overhead is shared. Competition is scarce and collaboration and cooperation is the more dominant theme.

Rural Washingtonians are also more likely to be uninsured, 12% vs. 9.8% in urban areas[3]. These rural health systems are far more likely to be financially stressed than their urban counterparts. And last but by no means least, rural Washingtonians have poorer health status than urban residents, leading to greater pressure on health resources. These differences are primarily linked to differences in age distribution, poverty, and education.

History and Background of Rural Health Clinics

Congress initiated significant federal legislation (Appendix J: Rural Health Legislation) that was passed in the early 1970's to address the lack of primary care health access. This included laws to develop strategies for recruitment and retention of primary care practitioners. The Rural Health Clinic Act (Pl-95-210) arose from communities in Appalachia that began to use nurse practitioners and physician assistants to augment the services of primary care physicians. These practitioners provided care when physicians were not physically available. This posed reimbursement problems for clinics serving Medicare patients, because Medicare required that a physician must be present when services were delivered in order to receive Medicare reimbursement.

By 1976, clinics in the Appalachia region of Tennessee had received congressional visits, and hearings on rural health access and providers were held. By early 1977, both the House and the Senate had introduced separate bills with slightly different focus. The initial Senate bill had a broader "physician extender" focus to include both rural and urban underserved areas, while the House Bill substantively became the future template for the Act, authorizing reimbursement for both Medicare and Medicaid beneficiaries in rural underserved areas.

[2] Recent Research and Data on the State of Rural Health In Washington State: (Schueler and Stuart, 2000)
[3] Washington Office of Financial Management (OFM). Health Insurance for the Non-Elderly in Washington State: Fact Sheet from Current Population Survey. (1999)

The Rural Health Clinic Act PL 95-210

The purpose of the Rural Health Clinics Act was to encourage and stabilize the provision of outpatient primary care in underserved rural areas utilizing physician assistants (PAs), nurse practitioners (NPs) and certified nurse midwives (CNMs) to augment physician services. Other health professionals were written into the Act in the 1990s; clinical psychologists and social workers were included to expand access to mental health services but are not included in RHC certification and productivity requirements. There are six categories that a federally certified Rural Health Clinic must comply with to maintain certification. They are:

1. Location - Rural Health Clinics must be located in communities that are both "rural and underserved." The following definitions apply:
    a. Rural Areas - Census Bureau designation as "non-urbanized";
    b. Shortage Area - A federally designated Health Professional Shortage Area (HPSA), a federally designated Medically Underserved Area (MUA) or an area designation by the state's Governor as underserved.
2. Physical Plant - May be permanent or mobile; has a preventative maintenance program; and has non-medical emergency procedures.
3. Staffing
    a. At least one Nurse Practitioner, Physician Assistant or Certified Nurse Midwife must be on-site and available to see patients 50% of the time the clinic is open to see patients. A waiver of this requirement is possible.
    b. On site Medical director (Physician) at least once every two-weeks.
4. Provision of Services - Each Rural Health Clinic must be capable of delivering outpatient primary care services. Specific laboratory services must be available on-site.
5. Emergency Care Services
    a. Care for common life-threatening injuries and acute illnesses available.
    b. Drugs used commonly in life-saving procedures available.
6. Records- Patient Health Records must be systematically maintained, guided by the clinic's written policies and procedures.

Note: Further information about the requirements for RHC certification may be found on the Department of Health's Office of Community and Rural Health website:
http://www.doh.wa.gov/hsqa/ocrh/RHC/rhcMminpg.htm

Rural Primary Care Options

To provide context to primary care services in rural Washington, Table 2.2 Primary Care Services by County (pg. 15) provides a detailed look at what types of healthcare institutions deliver primary care services by rural county.

These institutions are identified in the Institute of Medicine's (IOM) safety net definition and include federally qualified health centers, tribal clinics, public hospital districts, free clinics, and certified RHCs. Critical Access Hospitals (CAHs) are the most recent addition (Balanced Budget Act '97) to rural safety net programs by the Center for Medicare and Medicaid Services (CMS) . These hospitals, also paid on a cost-based reimbursement basis, are determined to be important for the stability of community health services (Hartley & Gale, 2003). Each of these categories of providers provides access to primary healthcare services with varying levels of state and federal regulation and subsidization. Each also meets the IOM safety net definition through either a mission to provide access to care or by providing access to substantial numbers of patients who are uninsured, are utilizing Medicaid, or are members of other vulnerable groups. Rural administrators must evaluate multiple options impacting the reimbursement and health delivery systems structure to determine what is most financially feasible for their market while also considering community interests. The following provider categories receive reimbursement through various state and federal programs, and have a significant influence on access to healthcare in Washington's rural communities.

Odessa Clinic

Rural Health Clinics (RHCs)

This federal certification program was established in 1977 to help extend primary care services in rural areas through enhanced Medicare and Medicaid reimbursement with the use of nurse practitioners,

physician assistants and certified nurse midwives. The Center for Medicare and Medicaid Services (CMS) defines Rural Health Clinics within two categories:

- An independent Rural Health Clinic may be owned by a community group, a tribe, or medical practitioner(s); and be either a non-profit or for-profit. Reimbursement for this category of RHC is capped for Medicare.
- A provider-based Rural Health Clinic can be owned by a hospital, home health agency or skilled nursing facility, and be either non-profit or for-profit. In Washington, all provider-based RHCs are owned by hospitals, hospital taxing districts or large clinics with inpatient hospital beds. Reimbursement for RHCs in this category is capped for facilities that have 50 beds or more. Facilities with fewer than 50 beds have no cap on their Medicare reimbursement.

For purposes of this report, the classifications of Rural Health Clinic ownership are Hospital-Affiliated (HA) which includes all of the CMS Independent clinics and Non-Hospital-Affiliated (NHA) which includes all of the provider based clinics.

Rural Hospitals

With two exceptions (Skamania and Wahkiakum), all counties in Washington have at least one hospital. Most rural hospitals are partially funded through the public hospital district taxing system and most of the eligible hospitals have converted to Critical Access Hospital (CAH) status. Though CAH facilities must maintain an emergency room, the purpose is not to replace primary care access. Local tax revenues, though important, are usually less than 10% of total revenues, with a larger revenue source coming from Medicare and Medicaid reimbursement. Although these state and federal programs provide additional resources, they do not guarantee that facilities will remain financially solvent. Rural hospitals often operate nursing homes and clinics; many times these clinics are RHCs. What is important about rural hospitals is that they have a key leadership role in holding rural healthcare systems together, and are a major employer and economic force in rural communities (Doeksen, Johnson & Willoughby, 1997).

Community and Migrant Health Centers (CMHCs)

Community and Migrant Health Centers (CMHCs), also referred to as Federally Qualified Health Centers (FQHCs), are required to take all patients regardless of ability to pay and to provide a comprehensive array of primary health care services, including oral and mental health. CMHCs are non-profit organizations whose community-based boards must have 51% consumer representation. They receive Medicaid and Medicare reimbursement enhancements and some federal support for development. Federal grant support to serve the uninsured (Section 330 grants) typically accounts for less than 10% of the CMHC operating budget, while an average of over 25% of patient visits were from the uninsured in 2003. An additional two-thirds of patient visits are Medicaid or Basic Health, with the remaining visits covered by Medicare or employer-based insurance. CMHCs which do not qualify for Section 330 grants, but meet all other requirements are referred to as Federally Qualified Health Center "look-alikes." Many CMHCs also receive grants to provide dental and medical services to the uninsured through the Washington State Health Care Authority's Community Health Services Program.

Tribal Clinics

Of Washington's 29 federally recognized tribes, 23 operate tribal health clinics**.** Four of these clinics are operated by the Indian Health Service and are open only to tribal members. Tribes operate the remaining clinics under federal Indian Self-Determination and Education Act (P.L. 93-638) contracts or compacts. Tribes increasingly are relying on Medicare, Medicaid, other third-party revenue sources, and revenue from tribal enterprises to fill the gap. Some Section 638 clinics are open to non-members, in part to improve access to third-party reimbursement. In some rural areas, tribal clinics have stepped-up to provide care because of a lack of providers willing to see Medicaid patients. The decision on how or whether to open tribal clinics to non-members is made locally and is subject to changes in reimbursement policy.

Free Clinics

Free or Charity Care Clinics are typically operated by faith-based or other community service organizations using donated materials and labor. Some receive Washington State Community Health Services grants. Most charity care clinics limit operation to a few hours or days per week. In 2004, Washington's free clinics provided more than 40,000 visits. Although the number and capacity of charity clinics is growing along with access concerns, in most areas, charity clinics represent far less than 1% of physician capacity.

Local Health Jurisdictions (Public Health Departments or Districts)

Local Health Jurisdictions in Washington provide limited direct services, which vary widely by district depending on their budgets. Some provide immunizations, well baby care, and WIC (Women, Infants, Children) services, but only King County currently provides direct primary care.

Role of Reimbursement Strategies

The government reimbursement strategies that support Federally Qualified Health Centers, Tribal Clinics and certified Rural Health Clinics are necessary to attract healthcare professionals to the more remote and frontier areas. In rural Washington, the ability of these primary care facilities to function depends a great deal on the leadership of local hospitals which have almost all made the decision to convert to Critical Access Hospital status. The few remaining hospitals in Washington that qualify for CAH status and have not converted are in the process of evaluating the structural and financial ramifications. Hospitals in general have the tasks of evaluating primary care access for the communities in their health service area and recruiting physicians to those areas. Without a hospital, this task falls to community leaders who are much less equipped to undertake the recruitment of health practitioners to their community. Local Health Jurisdictions (Public Health Departments or Districts) play a role in rural counties through the limited services they offer to primarily low-income women and children, but they do not have the ability to offer primary care services. Free clinics are much less likely to have a presence in rural areas because of the lack of primary care physicians to offer free services. FQHCs have a strong presence in these rural areas, representing 43% (N=21) of all FQHCs statewide. However, this represents only nine clinics spread throughout rural Washington state. Fifteen percent (N=20) of the tribal clinics are on three of the reservations located in rural Washington.

Table 2.2 Primary Care Services By County

These figures do not include urban sites with the exception of hospitals in counties with both urban and rural populations. (2003 data).

Washington County with RHCs	Private Practices	Certified RHC	# Non-Hospital-Affiliated	# Hospital-Affiliated	FQHC & Look-Alikes	Tribal Clinics	Free Clinics	# Hospital	% Public Hospital District	% Critical Access Hospital
Columbia	0	1	0	1	0	0	0	1	100%	100%
Ferry	1	1	0	1	3*	0	0	1	100%	100%
Garfield	0	1	0	1	0	0	0	1	100%	100%
Lincoln	0	4	0	4	0	0	0	2	100%	100%
Skamania	0	1	1	0	0	0	0	0	0%	0%
Adams	1	1	0	1	1	0	0	2	100%	100%
Jefferson	2	4	0	4	0	0	1	1	100%	100%
Klickitat	0	2	1	1	0	0	0	2	100%	100%
Okanogan	1	7	6	1	3	1	1	3	100%	100%
Pacific	3	3	1	2	0	1	0	2	100%	100%
Pend O'reille	0	2	0	2	1	0	0	1	100%	100%
San Juan	2	2	0	2	0	0	0	1	0%	0%
Stevens	2	3	3	0	4	1	0	2	0%	100%
Chelan	1	6	3	3	2	0	1	3	33%	66%
Clallam	18	7	4	3	0	4	2	2	50%	50%
Douglas	2	2	1	1	0	0	0	0	0%	0%
Grant	1	9	4	5	3	0	0	4	100%	75%
Grays Harbor	14	3	1	2	2	2	0	2	50%	50%
Island	7	4	1	3	0	0	0	1	50%	0%
Kittitas	0	5	4	1	0	0	1	1	100%	0%
Lewis	10	9	7	2	0	1	1	2	50%	50%
Mason	3	6	4	2	0	2	0	1	100%	0%
Skagit*	6	7	5	2	1	2	0	3	100%	0%
Walla Walla	2	3	2	1	2	0	1	2	0%	0%
Whitman	7	2	2	0	0	0	0	2	100%	50%
Benton	1	1	0	1	1	0	1	2	50%	50%
Snohomish*	3	3	2	1	1	4	0	4	66%	0%
Spokane*	5	1	1	0	0	1	0	5	0%	20%
Thurston*	1	2	1	1	0	1	0	2	0%	0%
TOTALS	93	102	54	48	21	20	9	55	37%	28%

*Metropolitan Statistical Counties

Rural Health Clinics in Washington State

Project Overview and Methodology

The Rural Health Clinic Initiative surveys were conducted in the summer and fall of 2003. At the time the surveys were conducted, 102 Rural Health Clinics had been certified by Medicare and invited to participate in the initiative. The source of information was provided by the state Department of Health, Facilities & Licensing (the agency that certifies Rural Health Clinics), and was cross-referenced with a list from the Office of Community and Rural Health. A list of the 102 clinics is provided in Appendix B, along with a map of the RHCs in Washington in Appendix C.

The Quantitative Survey

The Quantitative Survey included financial data and productivity data and was designed by East West Consulting, a private consulting firm in Bellingham, Washington, under contract from the Office of Community and Rural Health (OCRH). This survey was patterned after the high-level reporting roll-ups in a standard medical clinic chart of accounts. Other elements were added that reflect key variables in the Medicare cost reports for RHCs. In all cases, the financial or "quantitative" survey was designed so it could be easily compared to national benchmarks. The aim of the survey was to a) permit a comparison of this state's RHCs to primary care medical clinics in general, and b) to allow clinics to compare themselves individually to a variety of benchmarks. A key survey design decision by the project team was to construct the survey to measure the overall financial and performance elements of RHCs rather than only the RHC portions of these clinics. Many RHCs operate both RHC services and non-RHC services under the same corporate structure. From a public policy standpoint, the project team wished to assess the overall financial health of these RHCs and the degree to which RHC status contributed to success or failure.

The Qualitative Survey

OCRH contracted with Washington State's two Area Health Education Centers (Eastern Washington Area Health Education Center, Washington State University Extension in Spokane and Western Washington Area Health Education Center in Seattle) to develop and perform a qualitative survey of the clinics.

The Qualitative Survey was based on a survey done in Oregon in 2000-2001 (Oregon's Rural Health Clinics, January 2001) which was greatly expanded for use in Washington. Additional questions were added about Quality Indicators, Staffing Retention and Provider Satisfaction, Recruitment Methodology, Technology Usage and the Background Training/Education of Clinic Administrators.

Discussions between the AHEC team, the Executive Committee of the Rural Health Clinic Association of Washington, and representatives of the Washington State Hospital Association's Rural Hospital Committee and the Association of Public Hospital Districts, as well as OCRH staff, contributed to the design of the survey.

During the summer of 2003, each of the participating clinics was personally visited by AHEC staff. Prior to the personal visits, a copy of the instrument was mailed to each clinic. At each clinic, the administrator and at least one physician and one mid-level practitioner were interviewed. Usually the clinic administrator selected the providers (physician and mid-level) to respond to the provider portion of the survey. At a few sites, all of the providers asked to be interviewed.

The RHCs visited were equally distributed between the east and west sides of the state. Eighty-eight of the 102 potential clinics were visited. The sample was statistically valid, divided between the two sides of the state (forty-six of the potential fifty-two sites in western Washington provided at least some information, while forty-two of the potential fifty in eastern Washington were interviewed.).

The Observational Surveys

During site visits, the AHEC team made subjective observations of each clinic, evaluating such factors as the ease of locating the clinic using the address on file; the adequacy of signage; and the ability of the clinic to maintain patient privacy in the waiting room areas. Team members also noted whether or not information about sliding fee scales was displayed. Observations were noted on a five point Likert scale and were not shared with clinic staff.

Eighty-five percent (85%) of the clinics completed the qualitative surveys; 42% of the clinics successfully completed the quantitative surveys. Several issues prevented clinics from participating in the financial quantitative survey. A key issue for those multiple clinics which have a common owner was that the financial data is typically reported in a common cost report. This situation occurs with public hospital districts as owners as well as with private clinics that have multiple sites. The information is therefore difficult to identify on a single site basis. The most common reason cited by clinics that did not participate in the qualitative survey is a recent change in ownership. Clinics that chose to not participate

in either survey primarily indicated a lack of time to complete the surveys. Survey instruments used for the process are provided in Appendix H – Financial/Utilization Survey Instruments.

The Department of Health provided participation incentive funds to the Rural Health Clinic Association of Washington (RHCAW) to encourage clinics to participate. The Association planned to use the funds to implement additional training on topics identified through the survey, providing a direct benefit to all the participating clinics.

Survey Methodology

Drafts of both the quantitative and qualitative surveys were introduced at the 2003 annual meeting of the Rural Health Clinic Association of Washington. The purpose of the surveys and the goals and objectives were discussed with the meeting attendees and feedback was requested as to content and format. In June, a letter endorsing the process was sent to each clinic from the Department of Health, the RHCAW Board of Directors and the Association of Washington Public Hospital Districts. The quantitative survey was enclosed with the letter. To increase clinic participation, East West Consulting conducted followup emails and phone calls to clarify and respond to questions.

It should be noted that the clinics that are members of the two largest RHC systems in Washington state chose not to participate in any of the surveys.

The qualitative surveys were mailed to clinics in July. The two AHECs conducted on-site interviews with clinic managers and primary care providers through October. The closing date for all surveys was October 31, 2003.

Data Analysis

Though Rural Health Clinics can have many different characteristics, the data was analyzed and cross-tabulated by four types of independent variables. The most common variables identifying Rural Health Clinics are:

- Type of RHC Designation
    - Hospital-Affiliated: Though Hospital-Affiliated can indicate ownership by a hospital, a long-term care facility or a visiting nurse service, in Washington all Hospital-Affiliated clinics are owned by either public hospital districts (42%), non-profit hospitals (4%), for-profit hospitals (1%), or non-profit corporation (2%).

  - Non-Hospital-Affiliated: More than half of Non-Hospital-Affiliated Rural Health Clinics in Washington are for-profit independent practices (51%).

- Geographic Location

  Clinics are described as isolated, small town and large town. Due to shifting population density, areas that have been previously rural are often now in urban areas. Changing policy affects these clinics and will be addressed in the report.

- Clinic Size

  The number of primary care physicians practicing at the clinic determines clinic size. The cross tabulations are based on two or fewer physicians, 3-5 physicians, and greater than five physicians.

- Age as an RHC

  The length of time that an individual clinic had been certified as an RHC was divided by those clinics that had been certified for two full years or less and those that had been operated as an RHC for three years and more.

These variables will be used as the predictors for variation within the array of questions asked of the clinic participants. Some of the key objectives of the project are as follows:

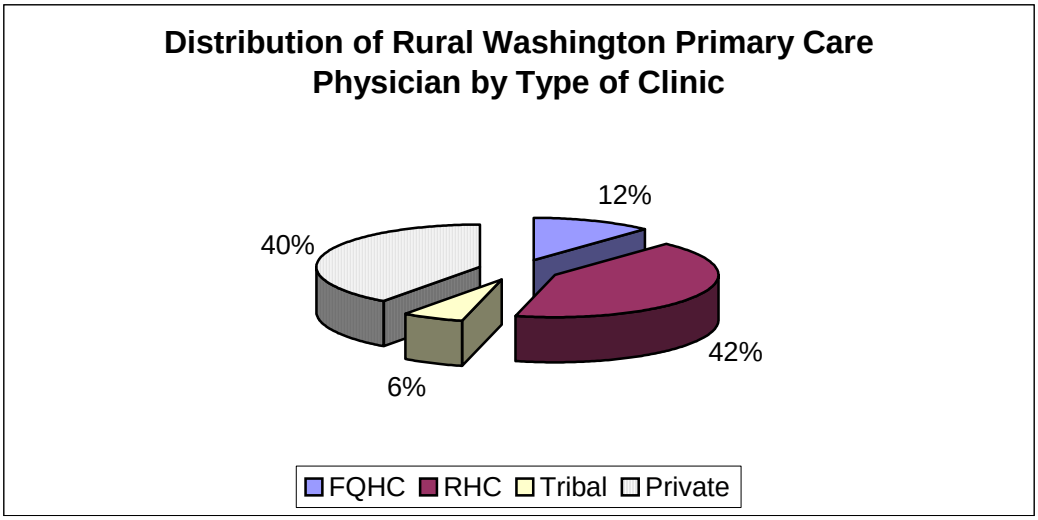
- Identify clinic stability as related to financial performance and patient volumes;
- Support the provision of a more stable environment where healthcare professionals can maintain healthcare practices in rural environments due to the Rural Health Clinic Services Act;
- Determine access to primary healthcare services for the community, including Medicare and commercial insured residents; and
- Determine the degree that Rural Health Clinics constitute the safety net in rural Washington communities, defined as access to primary healthcare services for Medicaid recipients and the uninsured.

Several indicators are used to establish correlation between Washington state RHCs and national benchmarks. Questions that correlate with the national Rural Health Clinic survey/analysis published in January 2003 by the Maine Rural Health Research Center were used for many of the qualitative responses. The quantitative analysis also used national benchmarks established by the Medical Group Management Association (MGMA).

Profile of Rural Health Clinics in Washington

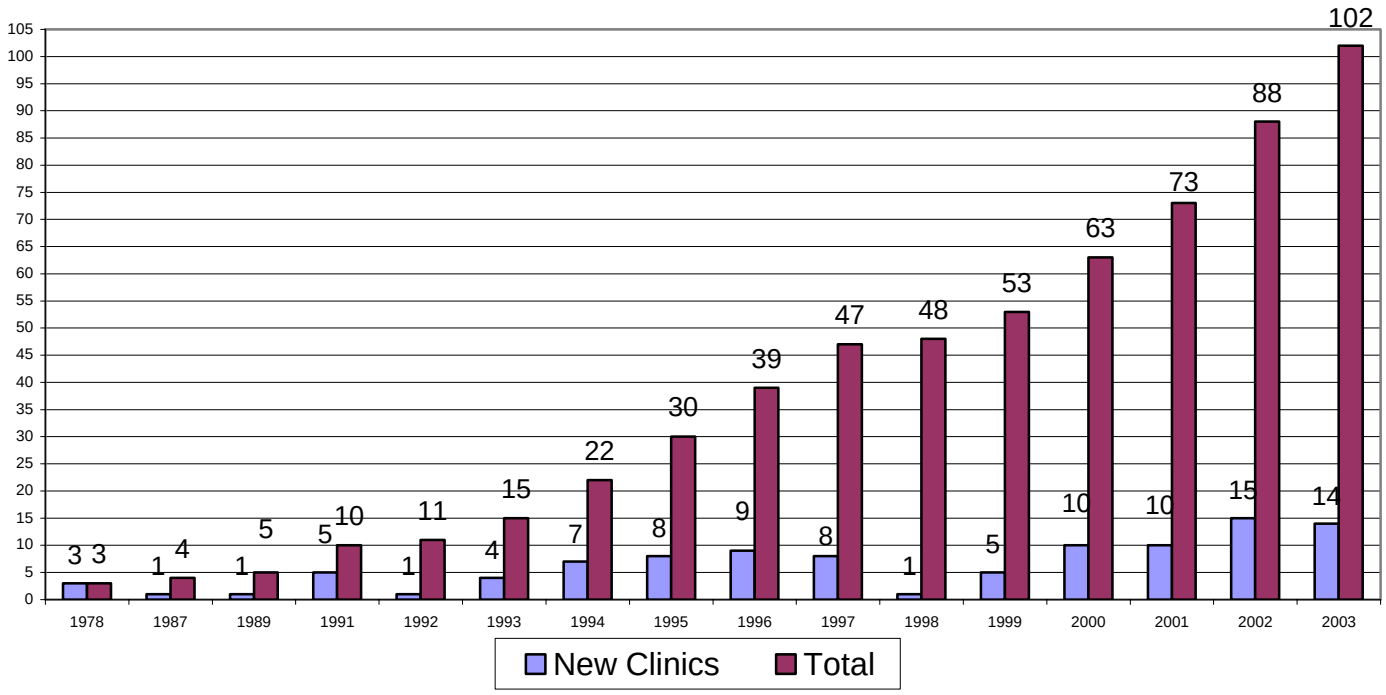
Forty-two percent (42%) of clinics located in rural areas of Washington are RHCs. The percent of RHCs has been increasing while the corresponding clinics with private ownership (40%) have been decreasing as they convert to RHC status. Federally Qualified Health Centers (12%) and tribal clinics (6%) make up the remainder of rural clinics.

Chart 3.1 Distribution of Rural Washington Primary Care Physician by Type of Clinic



The next chart shows the rapid increase in growth in RHCs over the past several years.

Chart 3.2 Growth of Federally Certified Rural Health Clinics in Washington State (2003)



The majority of RHCs are owned by free-standing, private for-profit entities (51%) and by Public Hospital Districts (42%).

Chart 3.3 RHCs by Owner Type (2003)

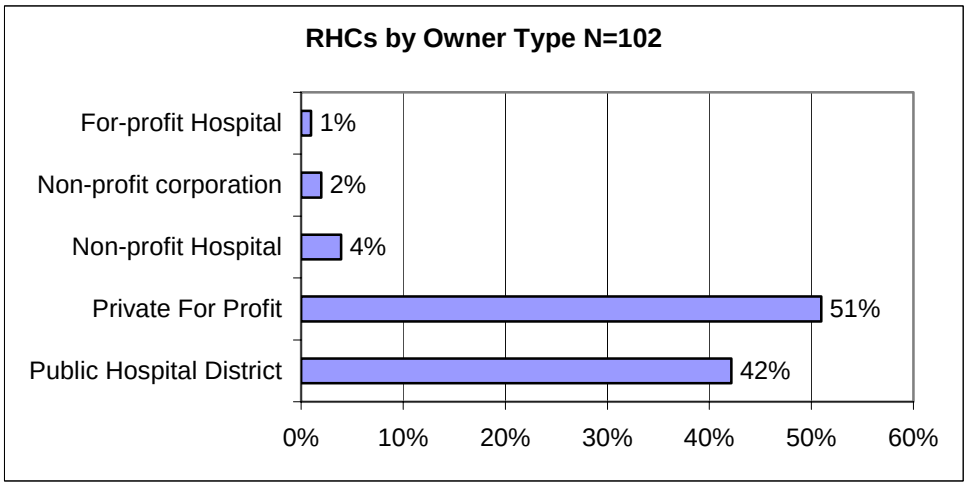


Chart 3.4 RHC Owners by Hospital Size

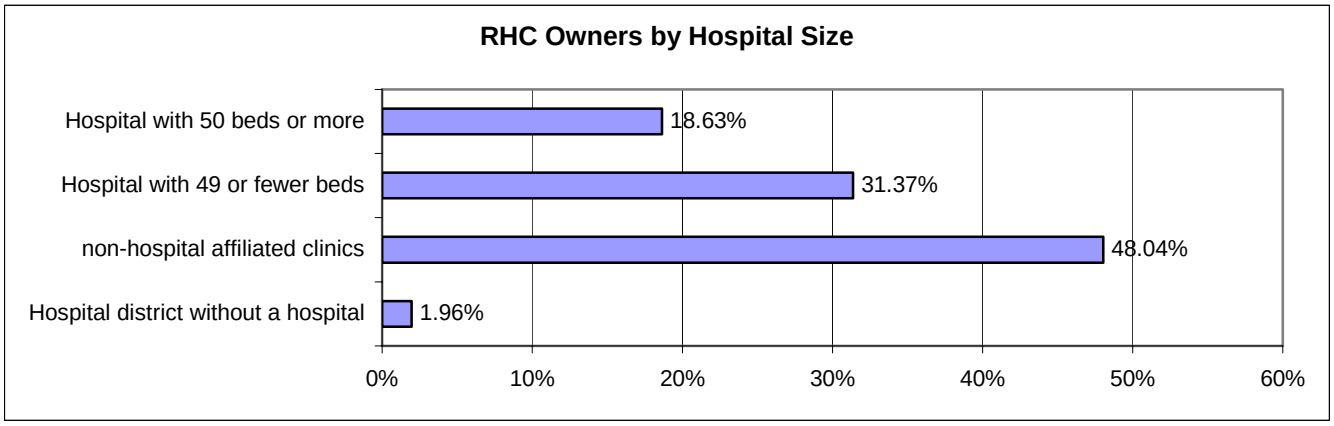
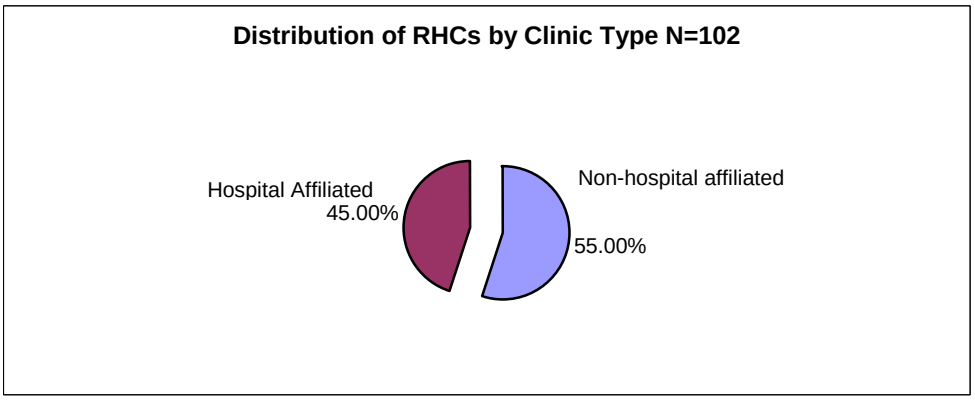


Chart 3.5 Distribution of RHCs by Clinic Type

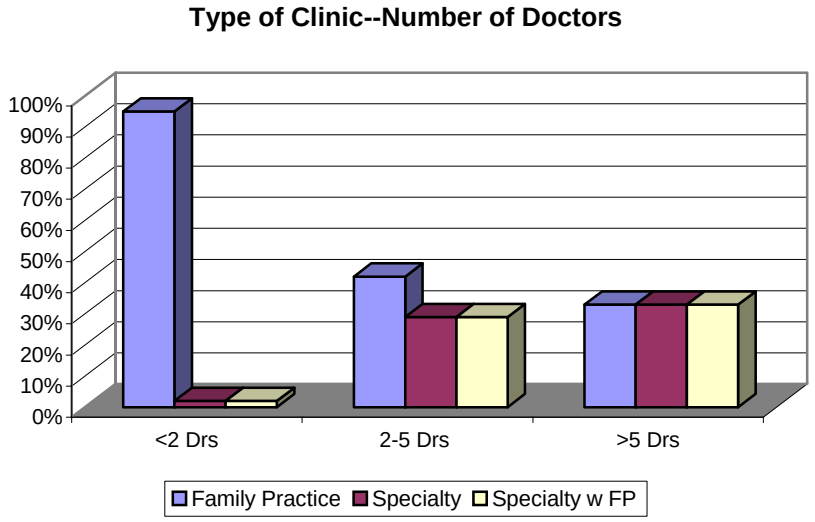


Practice Characteristics

Practice Type by Number of Physicians

Ninety-five percent (95%) of the clinics with 0-2 physicians were predominately family practice-oriented primary care. Two percent (2%) of these were specialty-only and 2% were mixed family practice and multi-specialty. Forty-two percent (42%) of clinics with more than two and less than five physicians provided family practice; 29% were specialty-only and 29% were both family practice and multi-specialty. Clinics with more than five physicians provided family practice 33%, specialty-only 33%, and family practice/multi-specialty 33%.

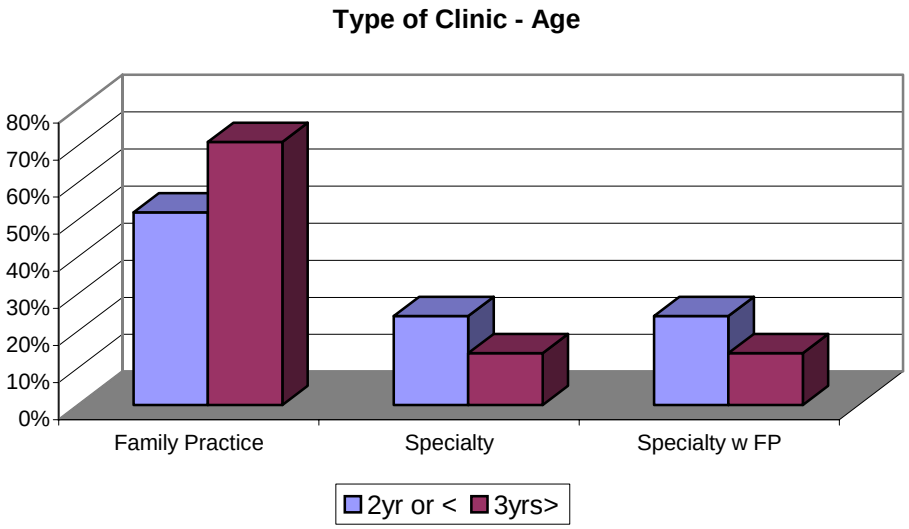
Chart 3.6 Type of Clinic—Number of Doctors



Practice Type by Age of Clinic

Thirty-two percent (32%) of the clinics had been in operation as a Rural Health Clinic for two years or less. Clinics which had operated as a Rural Health Clinic for two years or less operated as family practice clinics 52%, specialty-only 24%, and family practice/multi-specialty 24%. Sixty-eight (68%) of the clinics have been in operation as a Rural Health Clinic for three years or more. Clinics which had operated as a Rural Health Clinic for three years or more operated as family practice clinics 71%, specialty-only 14%, and family practice/multi-specialty 14%.

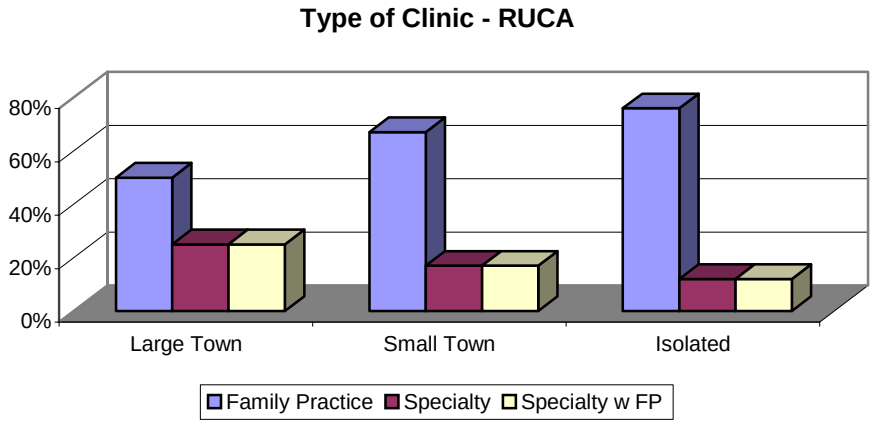
Chart 3.7 Type of Clinic - Age



Practice Type by RUCA Code

Seventy-six percent (76%) of the clinics in isolated towns provided family practice only; 12% provided specialty services only, and 12% were mixed family practice/multi-specialty. Sixty-six percent (66%) of the clinics in small towns provided family practice only; 17% provided specialty care only and 17% were mixed family practice/multi-specialty. Fifty percent (50%) of the clinics in large towns provided family practice only; 25% were mixed family practice/multi-specialty and 25% were specialty-only.

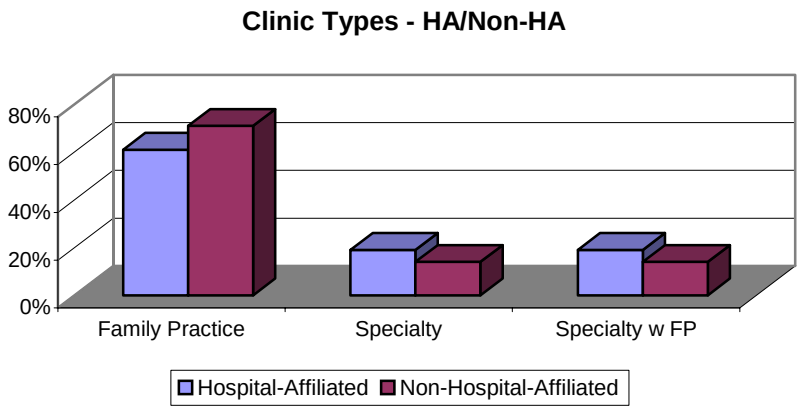
Chart 3.8 Type of Clinic - RUCA



Practice Type by Ownership Type

Sixty-one percent (61 %) of the clinics designated as Hospital-Affiliated provided family practice-only services; 19% were specialty-only and 19% were mixed family practice/multi-specialty. Seventy-one percent (71%) of the clinics designated as Non-Hospital-Affiliated provided family practice-only services; 14% were specialty-only and 14% were mixed family practice/multi-specialty.

Chart 3.9 Clinic Types - HA/Non-HA



Financial Data and Productivity Results

Methodology and Sample Validity

The RHC project team developed a separate survey to assess financial and other key numeric aspects of performance. This survey was patterned after the high-level reporting roll-ups in a standard medical clinic chart of accounts. Other elements were added that reflect key variables in the Medicare cost reports for RHCs. In all cases, the financial or "quantitative" survey was designed so it could be easily compared to national benchmarks. The aim of the survey was to a) permit a comparison of this state's RHCs to primary care medical clinics in general, and b) to allow clinics to compare themselves individually to a variety of benchmarks. A key survey design decision by the project team was to construct the survey to measure the overall financial and performance elements of RHCs rather than only the RHC portions of these clinics. Many RHCs operate both RHC services and non-RHC services under the same corporate structure. From a public policy standpoint, the project team wished to assess the overall financial health of these RHCs and the degree to which RHC status contributed to success or failure.

In July 2003, East West Consulting mailed a comprehensive cost survey to the existing 102 Rural Health Clinics in Washington. Clinics were asked to provide data for fiscal year 2002, the last full fiscal year at the time of the survey. It is important to emphasize that Rural Health Clinics are dynamic and ever-changing. The information provided in the surveys represents a snapshot in time and does not necessarily reflect what is happening in the individual clinics or even in Washington state as a whole at a later point in time.

After mailing the surveys, clinics were contacted to ensure they had received the survey as well as to answer any questions they might have had. East West Consulting also verified pertinent information like address and contact personnel, and screened all data for accuracy and completeness. In a number of instances, outlier information was identified and corrected in discussion with an individual clinic. Of the 102 surveys mailed, 43 usable surveys were returned. This 42% return rate was an adequate return overall. Table 4.1 below shows the distribution of responses by key characteristics of RHCs.

RHCs are generally smaller than typical physician clinics and many lack financial and administrative infrastructure. As a result, the survey was designed to be easier to complete than, for example, MGMA surveys or Medicare cost reports. (Responses received tracked very closely with the overall group of 102 clinics.)

The only exception to this was that the East West sample contained proportionally fewer RHCs in operation less than two years (28% compared to 38% of all RHCs). This is likely due to newer RHCs being less likely to have RHC operational data from cost reports.

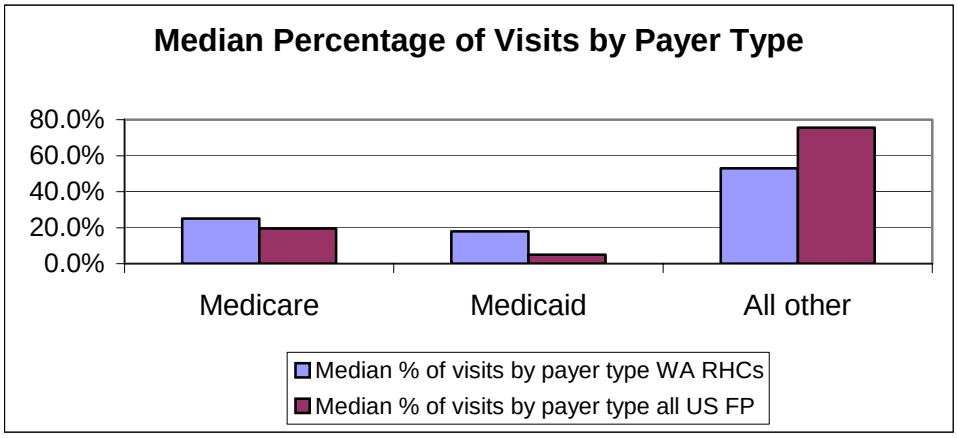
Table 4.1 Sample Validity of Cost Survey

Rural Health Clinics	Number of Clinics	% of Total Rural Health Clinics	Respondents	Number of clinics	% of respondent
# of RHC	102		# responding	43	42.16%
# of RHC East	52	51%	#responding east	22	51%
# of RHC west	50	49%	# responding west	21	49%
# of RHC Small Town	28	27%	# responding small town	11	26%
# of RHC Large town	24	24%	# responding large town	11	26%
# of RHC Isolated	50	49%	# responding isolated	21	49%
Hospital-Affiliated	48	47%	# responding Hospital-Affiliated	23	53%
Non-Hospital-Affiliated	54	53%	# responding Non-Hospital-Affiliated	20	47%
2 or less years as RHC	39	38%	2 or less years as RHC	12	28%
3+ years as RHC	63	62%	3+ years as RHC	31	72%

Understanding Rural Health Clinic Reimbursement System

Like virtually all primary care practices, RHCs receive revenue from a wide variety of sources. In general, however, these sources of revenue can be grouped into three clusters: Medicare, Medicaid, and all other—a composite of commercial insurance payments, self-payment and various miscellaneous public payers. RHC status directly affects only the first two payment types, Medicare and Medicaid. One of the key purposes of the RHC program is to create a financial incentive for these primary care practices to serve relatively more Medicare, Medicaid and uncompensated patients. As shown below in Chart 4.1, in Washington state, there is clear evidence that RHCs are serving this public purpose. This is especially pronounced for Medicaid where 18% of all RHC visits are Medicaid compared to only 5% for all US family practices. Five percent (5%) is the median Medicaid percentage for Washington family practices, as well.

Chart 4.1 Median Percentage of Visits by Payer Type



Medicare reimbursements for RHCs are received via specially designated fiscal intermediaries, one for provider-based clinics and another for free-standing clinics. Historically, Medicare has had distinct rules for each major type of RHC. For free-standing clinics, reimbursement is subject to a pre-determined cost cap or ceiling on per visit payments. In 2002, the year of this financial survey, that cost cap was $64.78. As of 2004, the cost cap is $68.65. Free-standing clinics annually submit a Medicare cost report and are paid the lesser of the cost cap or their actual cost. In Washington state, all free-standing clinics but one were being paid at the cost cap limit in 2002. In contrast, provider-based RHCs have not been subject to a cost cap. Like free-standing clinics, they submit an annual cost report but are paid at their calculated cost per visit. In 2002, this "cost" ranged from a low of $84.04 to a high of $243.62. The average for all reporting provider-based RHCs was $132.78. It is important to note that new regulations implemented in 2004 will subject a larger number of provider-based RHCs to the same cost cap which applies for the independents.

Medicaid reimbursement was initially driven from Medicare cost reports. The Washington Medicaid program trends these initial rates forward and, therefore, over time, may become less directly linked to costs and defined in cost reports. In Washington state, Medicaid reimbursement is also largely cost-based. While states must pay at least at the Medicare level, states are given discretion as to payment formulas. In Washington state, clinics are paid an all-inclusive rate for each visit, with all-inclusiveness based on RHC services only. DSHS will only pay for one visit/day. In 2002, this project's survey year, the all-inclusive rate varied from a low of $55.20/visit to a high of $125.90/visit. The average rate was $86.78 and the median rate of $82.32.

Washington state's managed care Medicaid program is called Healthy Options. Statewide, approximately 55% of RHC Medicaid patients are Healthy Options (HO) enrollees. Generally, the managed care plan

will directly pay the RHC at Medicaid fee-for-service levels. These fee-for-service levels (around $24/Relative Value Unit (RVU) for adults and $32-35/RVU for children) are below the RHC rate. To make up the difference, the state pays a "premium enhancement" directly to the RHC monthly. These premium enhancements are per-member per-month (PMPM) capitation payments and are not tied directly to encounters or visits. Thus, a clinic with a 500 person HO enrollment and an "enhancement rate" of $30 would receive $15,000 monthly or $180,000/year in addition to its fee-for-service payment from the health plan. In 2002, the range of PMPM enhancements was from a low of $19.12 to a high of $53.95; the average was $30.13 and median $29.23. 2003 average yearly HO enrollment at RHCs was 40,126. Thus, the total value of the RHC enhancement was around $14.5 million for the Washington RHCs.

Historically, physician commercial and out-of-pocket revenues were also mainly cost-based discounts from charges. With the increased awareness of Medicare's Resource-Based Relative Value System (RBRVS) payment system, however, commercial payers began negotiating this payment approach into their physician contracts. This practice reduced the physician clinic's ability to cost shift Medicare and Medicaid shortfalls or charity care onto commercial health plan payments. Now, the vast majority of physician commercial insurance receipts are, in effect, capped at a fixed amount per unit (for example, $46/RVU).

This change in commercial reimbursement methods has also increased the attractiveness of RHC cost-based reimbursement. For RHCs, in contrast to non-RHCs, the public payers (Medicare and Medicaid) generally pay more per visit than commercial payers in a state such as Washington, which has among the lowest commercial reimbursement levels in the country. For most clinics to either succeed from a financial perspective, or at least stay solvent, several aspects of performance need to line up well. These are:

1. The clinic providers need to be at least relatively productive.
    - Since revenue is generally on a per-unit of service or fee-for-service basis, providers need to produce enough visits to at least pay expenses.
2. The clinic needs to receive sufficient revenue per visit.
    - The higher the revenue per visit, the fewer visits the provider needs to produce in order to meet expenses. Providers generally seek payers with higher reimbursement per visit to increase overall revenue. For RHCs, this translates to higher percentages of Medicare and Medicaid.
3. The clinic needs to produce enough revenue to be able to pay its providers a competitive income.

- If providers are not paid competitively, they may migrate to areas which do pay competitively. Thus, a measure of an RHC's health is its ability to pay providers at least median compensation levels and increase retention.

4. The clinic must reasonably control its expenses.
    - Clinics have a degree of control over the number and type of support staff and the rates they are paid. As well, clinics can influence non-personnel expense and provider compensation. One way to measure expense control is the clinic's overhead rate (ratio of provider expense to total net revenue).

Taken in total, these four parameters influence clinic financial performance and help drive financial best practices. The interplay of performance in these four dimensions is strongly influenced by RHC's cost-based reimbursement system and, in large part, explains the variation in financial performance which will be described in greater detail later in this section of the report.

How Reimbursement Rates Vary and Why

Rural Health Clinics are paid a cost-based, all-inclusive per-visit rate. Independent RHCs and provider-based RHCs owned by hospitals with more than 50 beds were regulated to a $68.65 rate/visit in 2004. Provider-based RHCs owned by a hospital with less than 50 beds, however, are not subject to any rate cap; therefore, some clinics' Medicare rates per visit were as high as $243/visit. Most reimbursement rates, however, fell somewhere between $90 and $150/visit.

How RHCs Serve Rural Washington

As defined by the Office of Community and Rural Health (OCRH), the population of rural Washington was 1,048,893 in year 2000. Just fewer than 18% of all Washington state residents lived in these areas classified as rural.

According to data from OCRH, there were 612 primary care physicians in practice in rural Washington in 2000. This was 5.83 primary care physicians per 10,000 residents in contrast to 7.31 per 10,000 in the state as a whole, roughly 20% fewer than the state overall.

Residents of rural Washington have four broad options for a source of primary care. These are a) a private physician practice which is not an RHC; b) an RHC; c) a Federally Qualified Health Center (FQHC) or d) an Indian Health Service or Tribal facility. As noted earlier in Chart 3.1, in the year 2000, nearly 42% of rural Washington's primary care physicians practiced in RHCs. This was slightly more than private (non-RHC) practices (40%) and far greater than FQHCs (12%) and Tribal Facilities (6%). Undoubtedly, if this data was updated through 2004, the proportion of primary care physicians in RHCs would probably now approach 50%, given the rapid growth in the conversion to RHC status.

Altogether in 2002, Washington's 102 RHCs provided about 1.62 million patient visits. In that same year, rural Washington's one million plus residents had an expected number of patient care visits of 3,767,000. Thus, nearly half (49%) of rural Washington's primary care visits occurred at RHCs. Clearly, RHCs are playing an essential role in Washington's rural healthcare system and the importance of that role is increasing over time.

Financial Overview of Washington Rural Health Clinics

Because the 43 Washington RHCs responding represented a good cross-section of the 102 total RHCs, several of the findings below have been extrapolated to the entire universe of 102 clinics.

Key Findings: Financial Performance of Washington RHCs

- The total medical revenue for the 43 reporting clinics was $91,307,649.57 in 2002. For the entire group of 102 clinics this equates to $216,590,000. This represents only 1.1% of total Washington state personal healthcare spending and only 3.7% of state spending for physician services. However, as a factor in the rural economy and, in particular, the rural healthcare economy, the fiscal impact is far greater. For 2002, this is estimated at 9.4% of total rural healthcare spending per capita or 29% of all spending for rural physician services. Thus, relatively small amounts of spending are leveraging a large rural impact through the use of highly targeted subsidies.
- The median medical revenue per visit was $87.88, compared to the MGMA US family practice (FP) median of $95.99. Despite cost reimbursement, medical revenues per visit still fell well below (8%) average.

- The median medical revenue per physician was $471,499.44, compared to the MGMA US FP median of $470,775.00 and the MGMA median for Washington state of $460,913.00. Because RHCs make more extensive use of mid-level providers, revenue per physician neared national averages.
- The median operating cost per visit was $49.70, while the median MGMA US FP operating cost per visit is $63.80. Thus, operating costs per visit were 22% below overall national averages. Again, this is likely due, in good part, to heavier use of mid-levels increasing visit throughput and decreasing provider cost per visit.
- Median operating costs/physician was $266,462.59, which is lower than the US MGMA median of $273,724, but slightly higher than the Washington MGMA median of $245,661. These costs (exclusive of provider compensation) were roughly comparable to USA averages. Generally speaking, operating costs as defined for this purpose are non-personnel expenses.
- Total medical revenue after operating costs/physician of $166,789 was lower than both the US median at $192,773 and Washington median of $190,219. Because fewer dollars were available after paying expenses, Washington RHCs were more likely to have operating subsidies, typically tax levy support.
- Total physician costs/physician for RHCs was $176,361 which is lower than the US median of $180,728, but higher than the Washington median of $145,798. Washington primary care physician income is substantially lower than US averages due to low commercial reimbursement. Among RHCs a combination of higher public program reimbursement and operating subsidies for provider-based clinics offsets this disadvantage.
- Overall, the RHCs surveyed had a net positive income in 2002 of $1.9 million. For the entire group of 102 clinics this extrapolates to $4.5 million or a margin of 2%. This is somewhat lower than average margins experienced by Washington hospitals. This average, however, masks tremendous variation among the clinics with a range from a loss of $2 million to a gain of $2 million. Overall, 42% of reporting clinics experienced an operating loss in 2002. Operating losses are heavily concentrated among the provider-based clinics. Thus, clinics have greater access to operating subsidy revenues.
- The median overhead rate for RHCs was 60% in 2002; this is very close to the 2002 average for all US family practice clinics of 59.4%.

Productivity

Key Findings—Performance of Washington RHCs

Utilization data were generally stated in terms of patient visits, and a definition of visits was provided in the financial survey. This measure ("visit") was chosen because more clinics were able to report their data in this format rather than in RVUs (relative value units) or encounters. A single visit may encompass several "encounters," for example, a physician encounter and a lab encounter.

Clinics were also asked to segment their visits by major type of payer: Medicare, Medicaid, and "all other." In general, clinics could not easily segregate self-pay from commercial, L&I or other payment types. Therefore, an inclusive definition of "all other" was utilized. Most clinics could report Medicaid and Medicare because, at a minimum, they used these categories in their cost reports. Even so, the data for total visits is somewhat more complete than the payer type data.

To compare productivity (utilization) between clinics, several measures were used. Median and mean visits per MD FTE can be, and were, compared to MGMA benchmarks. However, it is important to remember that RHCs make much heavier use of mid-levels than typical US primary care practices. As a result, the project advisory committee asked East West Consulting to develop a measure for total visits/adjusted provider and to compare this to benchmarks as well. "Adjusted provider" treats an M.D./D.O. as 1.0 FTE and a mid-level as .5 FTE.

- For the 43 reporting clinics, total visits were 811,940. Assuming the 43 reporting clinics are representative, the entire group of 102 RHCs did about 1.62 million patient visits in 2002.
- There is significant variation in the number of visits per clinic. Among the 43 reporting clinics the average number of visits was 18,882, but the median was only 9,810. Several large clinics with more than 100,000 visits skew the average upward. In any event, both figures represent smaller practices than the national average for primary care group clinics of 24,752 visits.
- Another way to analyze utilization and productivity in a way that eliminates the distortion of variation in clinic size is to measure visits per physician and visits per provider. For Washington RHCs, the median per FTE physician was 5,126 visits. This compares favorably to the US median 4,215 and Washington median at 4,001. Analysis of the detailed data shows a strong correlation between the high ratios of mid-level to physician FTE and high rates of visits per MD FTE. Washington RHCs make much more extensive use of mid-levels than typical primary care

practices. For example, among the RHCs there are .74 mid-levels for every physician FTE, but for non-RHCs there is only .45 per physician FTE.

- In comparing productivity at the individual RHCs and benchmarking against other RHCs, the use of visits per adjusted provider FTE is a useful measure. It ranges from a low of 2,606 visits per adjusted provider to a high of 6,573. The median was 3,814, which compares unfavorably with US medians. It is important to note, however, that the US benchmarks implicitly include fewer mid-levels and this fact pulls up the national benchmarks. Mid-levels typically do half to 60% of the number of visits of a physician.
- The median Washington RHC had 25% of its visits from Medicare patients compared to 19.48% for the national benchmark.
- The median Washington RHC had 18% of its visits to Medicaid patients, compared to only 5% nationally and in the state comparison group. In other words, the proportion of Medicaid clients in RHC panels was more than 3 times that in non-RHCs. Clearly, the RHCs are a major source of access for Washington Medicaid.

In summary, the clinics themselves were highly productive. This is largely due to extensive use of mid-levels. The evidence about the productivity of individual practitioners is less compelling. These clinics are serving the public policy goal of disproportionately serving public payer patients.

Key Findings—Accounts Receivable

Because it represents work which has been completed but for which payment has not yet been received, AR is an important measure of a practice's performance. The management of AR will directly affect not only cash flow but ultimately income to the physicians or the practice itself.

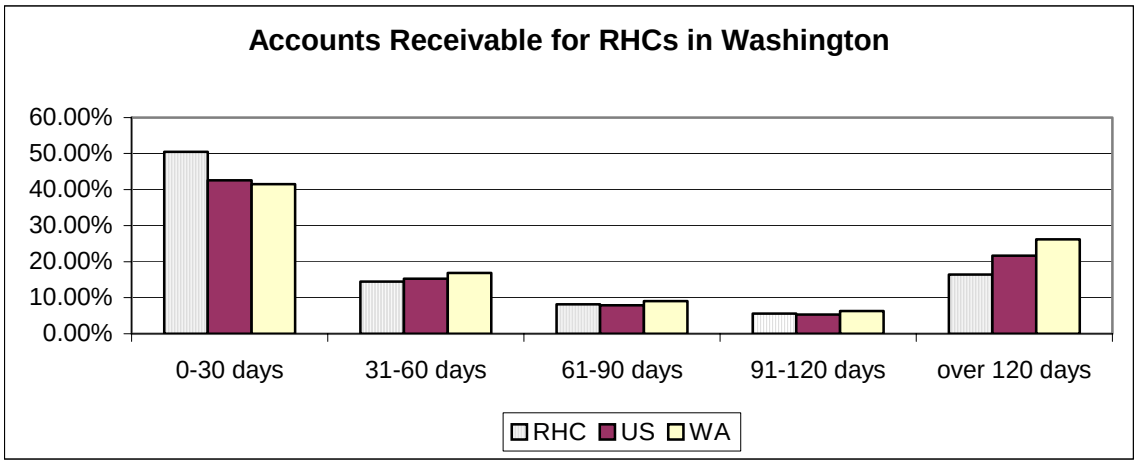
Nationally, a common benchmark is for AR greater than 91 days to be no more than 18.22% of total AR. Office visits should generally be billed an average of two to three days from the time of service. The remainder of AR thus represents the time it takes for the payer to reimburse the provider. There are many possible explanations for AR problems, such as:

- An inadequate number of billing personnel
- Lack of training or poor structuring of the billing role
- Turnover of staff
- Physicians and/or mid-levels are hindering the billing process

- Payers are slow to pay
- Errors in claims lead to rework

As shown in Chart 4.2, Washington's RHCs are, as a group, performing well in managing AR. Twenty-two percent (22%) of receipts are more than 90 days old compared to 27% for US family practices and 32.5% for Washington family practices. The primary reason for this good performance is likely to be a disproportionate amount of Medicare/Medicaid visits and the fact that these are billed electronically. RHCs are smaller than the average Washington primary care practice, so they are less likely to have specialized billing staff, and RHCs also have fewer billers per provider (.6/provider) compared to the benchmark (.7/provider).

Chart 4.2 Accounts Receivable for RHCs in Washington



Performance Variation by Clinic Characteristics

The variety of Washington RHCs and the attendant variation in their performance is striking. However, there are patterns related to key clinic characteristics. Clinic financial data in four sets of operating characteristics were compared: Hospital-Affiliated clinics vs. Non-Hospital-Affiliated clinics; clinics that had been RHCs less than 2 years vs. clinics that have been RHCs more than 3 years; geographic location of the RHCs based on RUCA definitions; and size of clinic by number of physicians.

How Do the Characteristics of Washington Non-Hospital-Affiliated (Non-HA) RHCs differ from Hospital-Affiliated (HA) Clinics?

Key Findings

- Non-Hospital-Affiliated clinics are bigger: on average they do twice as many visits and generate an average of more than twice as much total medical revenue.
- Non-Hospital-Affiliated clinics see a higher proportion of Medicaid: 21% vs. 16% for the provider-based RHCs.
- Revenue per visit is very similar ($88.92/non-HA vs. $86.92/HA), but the source of these revenues is different by payer type. For example, HA clinics with about the same proportion of Medicare visits generate 36% more Medicare revenue.
- Operating cost per visit was about 10% higher in HA clinics. There were greater variations in the cost structure.
- Physician cost/FTE was about 31% higher in the HA clinics.
- The median HA clinic lost $51,390/MD FTE (about the amount of the MD salary differential) compared to a gain of $9,771/MD FTE for the non-HAs; the losses, most often, were covered by subsidies from the owner hospitals.
- HA staffing showed substantial variation. The average non-HA practice had 3.06 MDs, but only 1.64 mid-levels, whereas the average HA practice had 1MD and 1.1 mid-levels. Support staff levels 3.00 FTE/provider (non-HA) vs. 2.77 (HA) were more comparable.
- The median HA RHC had been an RHC for 4 years longer than the non-HA.
- HA clinics have a clear pattern of operating in the relatively more rural, remote areas.

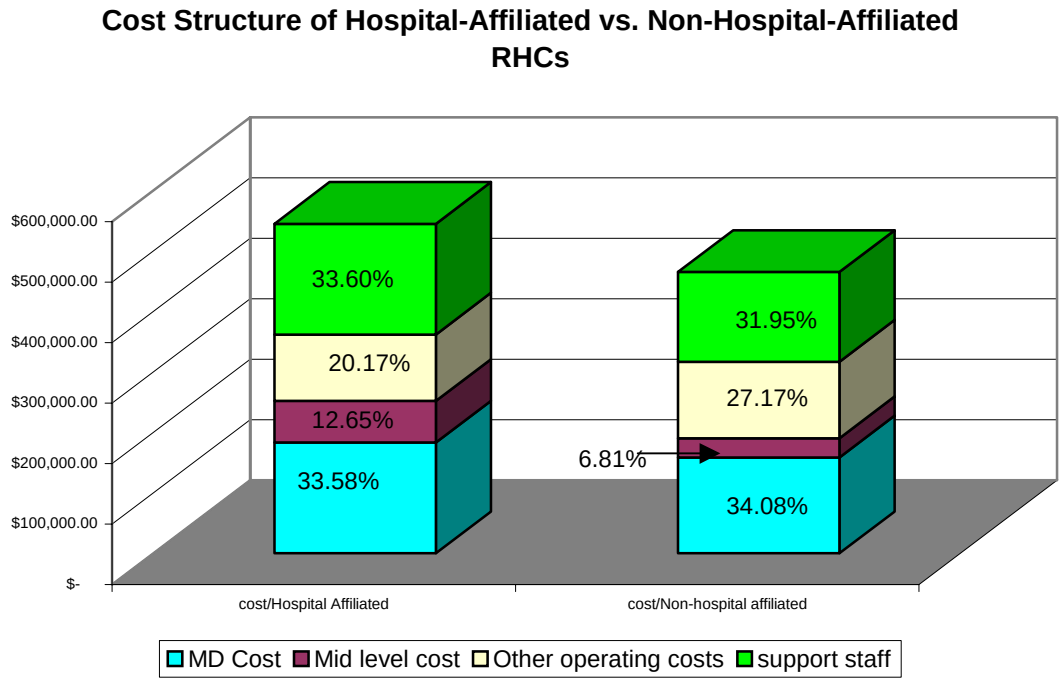
Table 4.2 shows utilization, financial, AR, and descriptive data for the 23 HA RHCs as a group compared to the 20 reporting non-HA RHCs. These data are then compared to the medians for all Washington RHCs, as well as to selected benchmarks for non-RHCs nationally and within the state.

Chart 4.3 illustrates the difference in cost structure between these two types of RHCs. Most striking is that the difference in total cost ($544,802.98) for HA clinics is 17% higher than the total costs of non-HA clinics. Non-personnel expense as a percent of total was 7% higher for the non-HA group but total mid-level expense as a percentage of total cost was nearly twice as high for the HA.

Table 4.2 Hospital-Affiliated vs. Non-Hospital-Affiliated RHCs

CLINIC ID	Hospital Affiliated median	Hospital affiliated average	Non-hospital affiliated median	Non-hospital affiliated average	**Average all RHC's**	**Median all RHCs**	MGMA U.S. FP Median
Utilization Statistics	N=23		N=20			N=43	
Total visits	7,303.00		14,406.00			9,810	
Total visits/MD FTE	5,234.00	5,564	5,007.00	5,284	5,424.00	5,126	4,215.00
Medicare visits	1,785.00		2,749.00			1,984	
% Medicare visits	24.00%		26.00%			25%	19.48%
Medicaid visits	826.00		3,082.00			1,678	
% Medicaid visits	16.00%		21.00%			18%	5.00%
Total other visits	3,416.00		7,736.00			5,248	
% other visits	54.00%		53.00%			53%	76.00%
Financial Statistics							
Total medical revenue	$ 585,164.87		$ 1,392,216.00			$ 855,786.00	
Total medical revenue/visit	$ 86.92		$ 88.92			$ 87.88	$ 95.99
Total medical revenue/MD FTE	$ 481,360.00	$ 495,088.00	$ 440,154.03	$ 476,190.85	$ 484,527.83	$ 471,499.44	$ 470,775.00
Total support staff FTE cost	$ 245,826.00		$ 375,823.00			$ 280,256.00	
Total support staff/MD FTE	$ 161,412.86	$ 183,053.05	$ 140,198.19	$ 148,648.02	$ 178,482.67		
Other Operating costs	$ 138,396.00		$ 364,412.00				
Other operating costs/MD FTE	$ 147,275.00	$ 109,898.02	$ 116,787.93	$ 126,385.81	$ 140,567.14		
Total operating cost	$ 430,461.00		$ 750,647.00			$ 552,984.00	
Total operating cost/visit	$ 50.85		$ 46.35			$ 49.70	$ 63.80
Total operating cost/MD FTE	$ 291,169.11	$ 310,183.48	$ 241,628.70	$ 275,033.82	$ 291,632.27	$ 266,462.59	$ 273,724.00
Total medical revenue after operating cost	$ 200,083.00		$ 619,525.00			$ 295,334.00	
Ttl med. Rev after operating cost/MD FTE	$ 187,662.25	$ 165,930.77	$ 156,149.62	$ 192,394.32	$ 180,719.23	$ 166,789.50	$ 192,773.00
Total midlevel cost	$ 83,438.00		$ 73,421.00			$ 81,727.00	
Total midlevel cost/MD FTE	$ 70,084.00	$ 68,906.19	$ 21,099.67	$ 31,679.09	$ 50,292.64	$ 41,639.77	
Total physician cost	$ 305,611.00		$ 89,290.00			$ 415,405.50	
Total physician cost/MD FTE	$ 185,725.39	$ 182,945.72	$ 141,715.53	$ 158,536.30	$ 170,411.15	$ 176,361.00	$ 180,728.00
Other revenue							
Other revenue/MD FTE		$ 21,358.57		$ 2,767.51	$ 9,096.62		
Net Practice Income or loss	$ (52,171.17)		$ 33,289.00			$ -	
Net Practice Income or loss/MD FTE	$ (50,390.00)	$ (66,481.41)	$ 9,771.49	$ 29,941.22	$ (13,887.25)	$ -	
Overhead Rate	66%		60%			62%	
Accounts Receivable							
% of Total AR 0 to 30 days	41.17%		54.32%			48.29%	42.61%
% of Total AR 31 to 60 days	15.17%		13.59%			14.47%	15.28%
% of Total AR 61 to 90 days	9.61%		5.96%			8.48%	7.90%
% of Total AR 91 to 120 days	6.49%		4.49%			6.11%	5.35%
% of Total AR over 120 days	23.86%		14.75%			16.54%	21.69%
Total % AR	100.00%		100.00%				
B&O as % of Total cost	14.01%		9.84%			10.53%	9.09%
Descriptive Variables							
# of MD FTE	1		3.06			2.00	5.2
# of Provider FTE	2.1		4.7			3.48	8
# of support FTE	6.15		14.25			9.00	26.6
Total support FTE/provider FTE	2.77		3.00			2.81	3.33
Total support FTE/MD FTE	3.57		3.57			3.57	5.12
support personnel exp. as % of ttl med.rev.	33.27%		32.23%			33.24%	32.24
Medicare Encounter Rate	$ 112.49		$ 64.78		$ 97.47		
Medicaid Encounter Rate	$ 94.83		$ 78.10				
# of years as RHC	7		3			6	
Ownership Type							
Location Type							
Practice Type							

Chart 4.3 Cost Structure of Hospital-Affiliated vs. Non-Hospital-Affiliated RHCs



How Does the Clinic's Location Relate to Its Operating Performance and Characteristics?

Key Findings

This report uses three categories to define location by RUCA standards: large town (10,000-50,000), small town (2,500-10,000), and isolated (under 2500) areas. Overall, 44% of the responding clinics were in isolated areas, 30% in small towns, and 26% in large towns.

- Not surprisingly, large town clinics had an average of 20,157 visits compared to 8,829 for small town clinics and 6,834 visits for isolated clinics. This finding is reasonable given larger market areas in large towns.
- Isolated clinics see the highest proportion of Medicare patients (31%); small town Medicare visits were 24% and large town Medicare visits were 14%. RHC clinic Medicare percentages were thus inversely proportionate to the population base in their area.
- Regarding proportions of Medicaid visits, RHCs in small town (24%) and isolated areas (18%) had higher median proportions of Medicaid patients.

- Revenue per visit was highest for small towns at $91.35/visit, but large town ($89.32) revenue/visit was not far behind. Clinics in isolated area ($75.00) had by far the lowest revenue/visit.
- Operating costs/visit was between $49.35 and $50.00 for all three locations. This observation means the variance in total expense is almost entirely a function of differences in provider expense (physician and mid-level).
- Physician cost/FTE was similar for isolated ($169,306.89) and large town ($164,766.52) area clinics. The small town median, however, was 15-18% higher at $195,032.
- Both isolated (-$27,307) and small town clinics (-$12,701) experienced a median net operating loss in 2002, but the large town clinics had a median net gain of $6,431. Of the clinics in large towns, only two had a net operating loss and in one of these instances the loss was negligible.
- AR performance did not vary significantly by location type.
- Building and Occupancy cost as a percentage of total expense was highest for isolated RHCs (14%).
- Overhead rates (70%) were also highest for RHCs in isolated areas.
- Isolated clinics had the smallest average number of doctors (1) and large town clinics had over four times as many doctors (6.4 FTE) as small town clinics (1.2). Not surprisingly, the total number of support staff was also substantially different with 6 FTE for isolated, 8.06 for small and 22.47 for large town clinics. However, total support/provider showed less variation across the board at 2.77, 3.38 and 2.91 FTE respectively. Still, small town clinics had 22% more support FTEs on average than did isolated clinics.

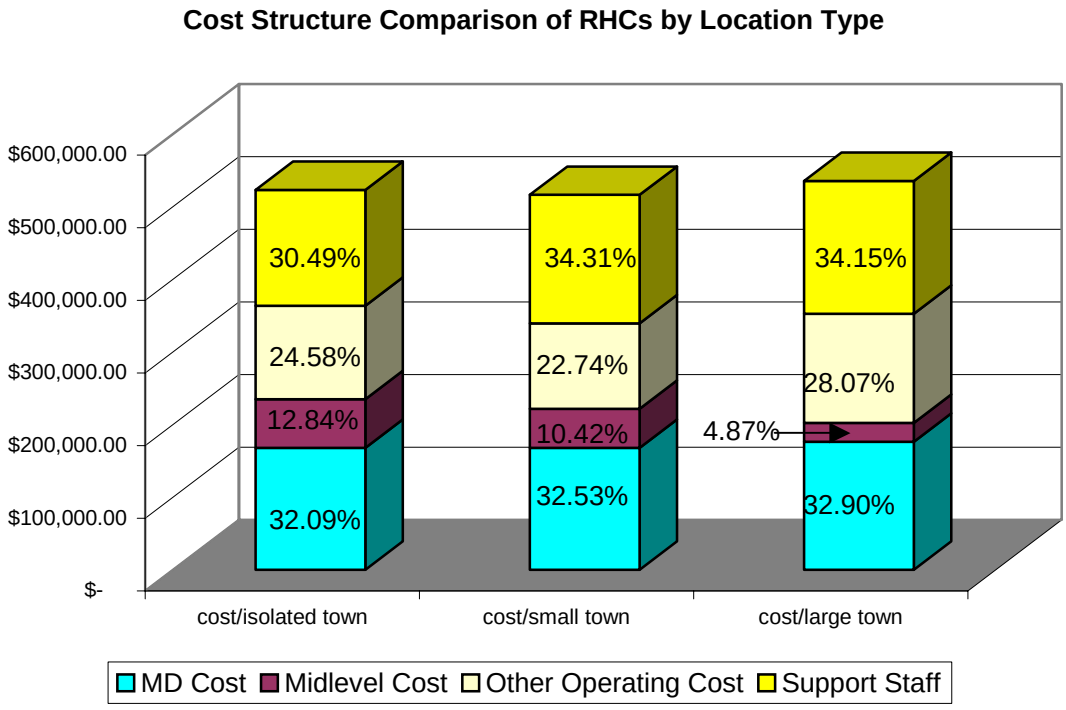
Taken in total, the findings support the hypothesis that the smaller the community, the more difficult it was to operate an RHC. Smaller communities tended disproportionately to require operating subsidies and had a more difficult time generating higher revenues per visit. This was likely due to lower volumes of visits.

As shown in Table 4.3, the total cost of running a large town clinic on a per FTE MD basis was only marginally higher. But lower revenues in isolated areas were responsible for poorer financial results. Among RHCs, there appears to be very real economies of scale in the use of mid-levels.

Table 4.3 RHCs by Location

CLINIC ID	Isolated Median	Isolated Average	Small town Median	Small town average	Large town Median	large town average	average all RHCs	Median all RHCs	MGMA U.S. FP Median
Utilization Statistics	N=19		N=13		N=11			N=43	
Total visits	6,834.00		8,829.00		20,157			9,810	
Total visits/MD FTE	6,075.00	6,192.00	5,667.00	5,500.00	4,004	4,372	5,424.00	5,126	4,215.00
Medicare visits	1,786.00		1,589.00		4,350			1,984	
% Medicare visits	31.00%		24.00%		14%			25%	19.48%
Medicaid visits	682.00		2,818.00		4,702			1,678	
% Medicaid visits	18.00%		24.00%		12%			18%	5.00%
Total other visits	2,849.00		3,737.00		13,690			4,870	
% other visits	54.00%		49.00%		62%			53%	76.00%
Financial Statistics									
Total medical revenue	$ 564,990.00		$ 599,495.74		$ 3,105,790.00			$ 855,786.00	
Total medical revenue/visit	$ 75.66		$ 91.35		$ 89.32			$ 87.88	$ 95.99
Total medical revenue/MD FTE	$ 461,638.89	$ 494,928.27	$ 556,480.90	$ 500,432.13	$ 382,010.97	$ 453,512.52	$ 484,527.83	$ 471,499.44	$ 470,775.00
Total support staff FTE cost	$ 169,230.00		$ 281,482.00		$ 665,540.52			$ 280,256.00	
support staff/MD FTE		$ 159,344.32		$ 176,995.52		$ 182,741.37	$ 178,482.67		
Total operating cost	$ 376,851.13		$ 486,788.00		$ 1,274,370.50			$ 552,984.00	
Total operating cost/visit	$ 49.35		$ 49.61		$ 50.00			$ 49.70	$ 63.80
Total operating cost/MD FTE	$ 317,293.33	$ 315,776.01	$ 275,404.58	$ 301,785.19	$ 212,778.69	$ 256,453.89	$ 291,632.27	$ 266,462.59	$ 273,724.00
Other Operating costs									
Other costs/MD FTE		$ 128,452.00		$ 117,279.00		$ 150,220.23	$ 140,567.14		
Total medical revenue after operating cost	$ 193,396.33		$ 302,820.00		$ 796,027.50			$ 295,334.00	
Ttl med. Rev after operating cost/MD FTE	$ 175,198.89	$ 166,355.69	$ 190,190.89	$ 198,956.93	$ 146,764.93	$ 162,694.78	$ 180,719.23	$ 166,789.50	$ 192,773.00
Total midlevel cost	$ 65,027.00		$ 100,610.00		$ 89,559.00			$ 81,727.00	
Total midlevel cost/MD FTE	$ 62,708.07	$ 67,080.58	$ 38,742.62	$ 53,771.16	$ 15,029.46	$ 26,080.11	$ 50,292.64	$ 41,639.77	
Total physician cost	$ 159,038.27		$ 341,933.57		$ 927,940.15			$ 415,405.50	
Total physician cost/MD FTE	$ 169,306.89	$ 167,668.35	$ 195,032.62	$ 167,775.93	$ 164,766.52	$ 176,026.70	$ 170,411.15	$ 176,361.00	$ 180,728.00
Other revenue	$ 45,472.57		$ 8,760.34		$ 100,877.33				
Other revenue/MD FTE	$ 45,014.72	$ 24,238.70	$ 5,116.55	$ 2,325.70	$ 10,758.47	$ 3,227.54	$ 9,096.62		
Net Practice Income or loss	$ (50,171.33)				$ 38,113.00			$ -	
Net Practice Income or loss/MD FTE	$ (27,306.89)	$ (28,014.76)	$ (12,700.67)	$ (16,658.02)	$ 6,431.24	$ 6,113.62	$ (13,887.25)	$ -	
Overhead Rate	70%		57%		60%			62%	
Accounts Receivable									
% of Total AR 0 to 30 days	45.67%		48.72%		49.62%			48.29%	42.61%
% of Total AR 31 to 60 days	16.63%		13.85%		14.80%			14.47%	15.28%
% of Total AR 61 to 90 days	8.18%		9.97%		8.43%			8.48%	7.90%
% of Total AR 91 to 120 days	6.67%		6.28%		5.64%			6.11%	5.35%
% of Total AR over 120 days	17.57%		16.54%		16.83%			16.54%	21.69%
Total % AR	100.00%								92.83%
B&O as % of Total cost	14.01%		8.66%		10.53%			10.53%	9.09%
Descriptive Variables									
# of MD FTE	1		1.2		6.4			2.00	5.2
# of Provider FTE	2		2.4		8.45			3.48	8
# of support FTE	6		8.06		22.47			9.00	26.6
Total support FTE/provider FTE	2.77		3.38		2.91			2.81	3.33
Total support FTE/MD FTE	4.66		3.39		3.43			3.57	5.12
support personnel exp. as % of ttl med.rev.	34.00%		32.00%		31.00%			33.24%	32.24
Medicare Encounter Rate	$ 97.60				$ 91.16			$ 86.76	
Medicaid Encounter Rate									
# of years as RHC	8		3		3			6	
Ownership Type									

Chart 4.4 Cost Structure Comparison of RHCs by Location Type



What Impact did Length of Time as an RHC Have on Performance?

Prior to conducting this survey, East West Consulting had hypothesized that the benefits of being an RHC would be greatest for those who had held RHC status the longest. In theory, those who had been RHCs longer had learned the system better and would have had had a longer time to stabilize operations.

Twenty-eight percent (28%) of the clinics (12) in the sample had been RHCs for less than 3 years and the remainder had been RHCs more than 3 years. As noted earlier, "newer" RHCs were statistically less likely to participate in this survey.

Key Findings

- Longer tenured RHCs (3+ years) had a median of 5,610 visits/MD FTE compared to 4,867 for the newer RHCs.
- Newer RHCs were somewhat less likely to have high proportions of Medicare but somewhat more likely to have a larger Medicaid mix. These differences, however, are not significant.

- Medical revenue/visit was similar for both cohorts but medical revenue/MD FTE at $503,308 was 13% higher at longer operating RHCs than for the newer clinics at an average of $439,453. These experienced RHCs were performing better than state and national norms on this measure.
- After paying all expenses (support staff and non-personnel costs) experienced RHCs at $194,871/MD FTE had 33% more dollars available for provider compensation than did newer RHCs at $146,754/MD FTE. This results in better provider compensation (9% greater) and lower operating costs.
- AR performance was very similar for both cohorts.
- Newer RHCs were larger than experienced RHCs. Among the newer cohort, there was an average of 5.25 MD FTE and 20.61 support FTE. This contrasts to 1.6 MD FTE and 8.16 support FTE for the experienced cohort.
- Overhead rates were identical.

As displayed in Table 4.4, the differences in the proportion of resources allocated to major expense categories are similar among newer and more experienced RHCs. However, the total operating cost of the older RHCs is 21% higher than the newer RHCs.

As displayed in Chart 4.4, the cost structure of the RHCs varied according to location. The large town clinics had a higher percentage of costs associated with MDs than mid-levels reflecting a greater use of MDs in the large town clinics as compared to the small town and isolated towns which employed more mid-levels. The costs associated with operating expenses in isolated and small towns were slightly lower than in large towns. The percentage of costs attributed to support staff was essentially the same in all location categories.

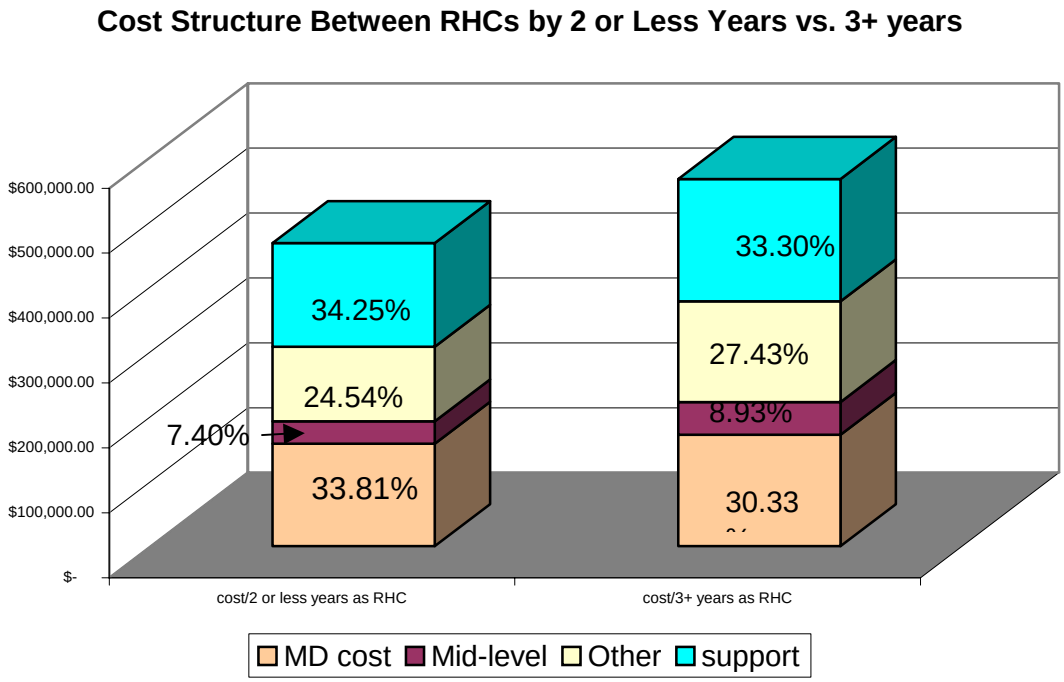
In overview, as can be seen in Chart 4.5, the older RHC total costs/MD are 21% higher. Yet, these clinics do not have a significantly higher operating deficit. This strongly suggests that the experienced clinics are gaining 21% or more revenue/MD and thus can afford the more costly expense structure. From a public policy standpoint, length of time as an RHC does lead to greater stability of the clinic.

Wenatchee Valley Clinic - Omak

Table 4.4 Older vs. Newer RHCs

CLINIC ID	2 or less years median	2 or less average	3+ years median	3+ years average	Average All RHCs	**Median all RHCs**	MGMA U.S. FP Median	MGMA WA FP Median
Utilization Statistics	N=12		N=31			N=43		
Total visits	19,697.00		8,058.00			9,810		
Total visits/MD FTE	4,561.00	4,867.00	5,667.00	5,610.00	5,424.00	5,126	4,215.00	4,001.00
Medicare visits	3,092.00		1,981.00			1,984		
% Medicare visits	22.00%		26.00%			25%	19.48%	
Medicaid visits	4,877.00		1,030.00			1,678		
% Medicaid visits	21.00%		16.00%			18%	5.00%	
Total other visits	9,693.00		3,679.00			4,870		
% other visits	60.00%		53.00%			53%	76.00%	
Financial Statistics								
Total medical revenue	$ 1,842,031.00		$ 599,495.74			$ 855,786.00		
Total medical revenue/visit	$ 89.32		$ 86.60			$ 87.88	$ 95.99	
Total medical revenue/MD FTE	$ 431,499.85	$ 439,453.28	$ 520,414.89	$ 503,308.89	$ 484,527.83	$ 471,499.44	$470,775.00	$ 460,913.00
Total support staff FTE cost	$ 604,010.00		$ 254,755.50			$ 280,256.00		
Total support staff/MD FTE		$ 159,968.00		$ 188,402.75	$ 178,482.67			
Total operating cost	$ 1,131,070.50		$ 486,788.00			$ 552,984.00		
Total operating cost/visit	$ 49.03		$ 49.80	$ 297,625.64		$ 49.70	$ 63.80	
Total operating cost/MD FTE	$ 266,398.90	$ 276,049.52	$ 266,462.59		$ 291,632.27	$ 266,462.59	$273,724.00	$ 245,661.00
Other Operating costs						$ 23,828,941.15		
Other operating costs/MD FTE		$ 114,579.00		$ 155,182.33	$ 140,567.14			
Total medical revenue after operating cost	$ 530,212.50		$ 229,801.00			$ 295,334.00		
Ttl med. Rev after operating cost/MD FTE	$ 146,764.93	$ 146,754.65	$ 188,703.63	$ 194,871.13	$ 180,719.23	$ 166,789.50	$192,773.00	$ 190,219.00
Total midlevel cost	$ 106,000.24		$ 70,727.50			$ 81,727.00		
Total midlevel cost/MD FTE	$ 25,104.41	$ 34,559.55	$ 38,742.62	$ 50,531.64	$ 50,292.64	$ 41,639.77		
Total physician cost	$ 587,916.00		$ 287,376.00			$ 415,405.50		
Total physician cost/MD FTE	$ 141,667.24	$ 157,889.67	$ 180,107.14	$ 171,597.93	$ 170,411.15	$ 176,361.00	$180,728.00	$ 145,798.00
Other revenue	$ 134,139.50		$ 33,305.03					
Other revenue/MD FTE	$ 2,116.43	$ 2,637.19	$ 285.93	$ 14,221.45	$ 9,096.62			
Net Practice Income or loss	$ 3,535.76		$ -			$ -		
Net Practice Income or loss/MD FTE	$ 1,943.83	$ (4,278.03)	$ (1,936.00)	$ (13,608.55)	$ (13,887.25)	$ -		
Overhead Rate	62%		62%			62%		
Accounts Receivable								
% of Total AR 0 to 30 days	49.43%		47.15%			48.29%	42.61%	41.52%
% of Total AR 31 to 60 days	13.92%		14.81%			14.47%	15.28%	16.89%
% of Total AR 61 to 90 days	6.36%		8.50%			8.48%	7.90%	9.11%
% of Total AR 91 to 120 days	4.51%		6.65%			6.11%	5.35%	6.29%
% of Total AR over 120 days	16.54%		16.54%			16.54%	21.69%	26.20%
Total % AR							92.83%	100.01%
B&O as % of Total cost	8.38%		12.24%			10.53%	9.09%	
Descriptive Variables								
# of MD FTE	5.25		1.6			2.00	5.2	5
# of Provider FTE	6.63		2.31			3.48	8	7.25
# of support FTE	20.61		8.16			9.00	26.6	26.3
Total support FTE/provider FTE	2.97		2.77			2.81	3.33	
Total support FTE/MD FTE	4.42		3.49			3.57	5.12	4.67
support personnel exp. as % of ttl med.rev.	35.00%		32.00%			33.24%	32.24	25.84%
Medicare Encounter Rate	$ 97.19		$ 92.68			$ 86.76		
Medicaid Encounter Rate								
# of years as RHC	1					6.00		
Ownership Type								

Chart 4.5 Cost Structure Between RHCs by 2 or Less Years vs. 3+ Years



How Did the Size of the Clinic Affect Financial Performance?

For analytic purposes, the clinics were grouped into three clusters to compare performance characteristics. These were: clinics with two or fewer physicians (small clinics), those with 2.01 to 5.0 FTE physicians (mid-sized), and RHCs with 5.01 or more physicians (large RHCs). The smallest clinics were generally single-specialty clinics. Mid-sized clinics included many single-specialty with a few multi-specialty. The large clinics were generally multi-specialty through there were also large single-specialty clinics. The largest group, 51% of the total sample, were small clinics. Nineteen percent (19%) were large clinics.

Key Findings

- As would be expected, clinics with the fewest number of doctors had the fewest visits, 63% fewer visits than medium size clinics and 89% fewer visits than large clinics.
- Regarding productivity, the small clinics saw a median of 6,227 visits/MD FTE. This correlated strongly with their higher mix of mid-levels (1:1). For mid-sized clinics, the median was 4,377 and for large clinics it was 5,007. In all three instances, these medians were higher than national or state benchmarks.

- Patient mixes were not significantly different among the three size cohorts.
- Revenue/visit was lowest for small clinics with $74.60/visit. This was considerably lower than both the medium sized ($92.72) and large clinics ($96.29). This lower revenue was the main cause for poorer financial performance in the small clinics.
- Medical revenues/MD FTE were highest at the large clinics ($541,250) and these were substantially ahead of state and national benchmarks. Lowest/MD revenues were in the mid-sized clinics at $454,561.
- Operating costs/visit was similar for small ($49.80) and medium clinics ($46.87) but almost $20 more/visit for large clinics ($61.15). This appears to be mainly due to the greater tendency of large clinics to invest in ancillary services.
- Physician costs/FTE were very different among the three size groupings. Small clinic physician compensation was $147,160 compared to $180,107 for medium sized clinics and $177,229 for large clinics. Lower medical revenues meant there was less cash available for provider compensation.
- There was substantial variation between the three size groupings for net operating gain or loss. Small clinics had a net loss of $36,500, but medium and large clinics showed net gains of $22,800 and $35,800 respectively.
- The median number of physicians at small clinics was one. Mid-sized clinics had 3.06 doctors and large clinics had 8.65.
- Total support FTE/provider FTE were much higher at large clinics (6.07) compared to 3.0 at small clinics and 3.57 at mid-sized clinics. At the large clinics, richer support staff levels drive increased productivity and support ancillary services.
- The overhead rate at the small clinics was 68%. Mid-sized clinics did well in controlling expenses at 49% and large clinics allocated 60% of net revenue to overhead. In the case of large clinics, this appears to relate to increased throughput of visits and added ancillary activity.
- The large clinics had the best AR performance at 69% less than 60 days. The next best cohort (mid-size) was at 60%.
- Building and occupancy as a percent of total cost declined with clinic size.

In summary, each of the three size groups appears to be pushing different business strategies. As shown in Table 4.5, and Chart 4.6, mid-size clinics tended to keep overhead low and were less costly to operate.

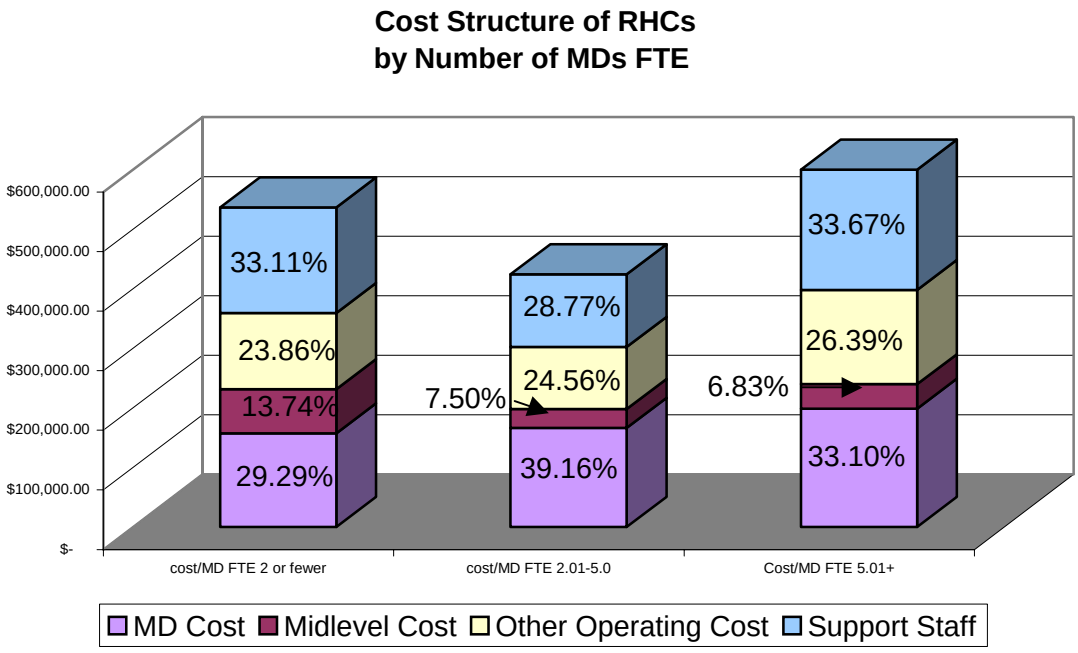
Small clinics, unable to achieve economies of scale and volumes to support services, tended to rely on operating subsidies. And the large clinics were often pursuing diversification (ancillary and specialty) strategies while increasing provider productivity.

North Valley Family Medicine - Tonasket

Table 4.5 RHC by Number of Doctors

CLINIC ID	Median for MDs 2.0 and less	Average for MDs. 2.0 and less	Median for MDs 2.01-5.00 FTE	Average for MDs 2.01-5.00 FTE	Median for MDs 5.01 + FTE	Average for MDs 5.01 + FTE	Average all RHCs	Median all RHCs	MGMA U.S. FP Median	MGMA WA FP Median
Utilization Statistics	N=22		N=13		N=8			N=43		
Total visits	5,325.00		14,644.00		48,484			9,810		
Total visits/MD FTE	6,227.00	6,261.00	4,377.00	4,531.00	5,007	5,308	5,424.00	5,126	4,215.00	4,001.00
Medicare visits	961.00		5,117.00		8,099			1,984		
% Medicare visits	23.00%		26.00%		27%			25%	19.48%	
Medicaid visits	714.00		2,581.00		7,526			1,678		
% Medicaid visits	21.00%		14.00%		17%			18%	5.00%	
Total Other visits	2,780.00		7,803.00		24,455			4,870		
% Other visits	54.00%		49.00%		60%			53%	76.00%	
Financial Statistics										
Total medical revenue	$ 469,990.00		$1,417,805.00		$ 3,735,790.00			$ 855,786.00		
Total medical revenue/visit	$ 74.60		$ 92.72		$ 96.29			$ 87.88	$ 95.99	
Total medical revenue/MD FTE	$ 480,609.34	$ 485,951.53	$ 454,560.71	$ 455,375.26	$ 541,250.00	$ 517,944.10	$ 484,527.83	$ 471,499.44	$470,775.00	$460,913.00
Total support staff FTE cost	$ 148,701.54		$ 386,235.00		$ 1,472,081.00			$ 280,256.00		
support staff/MD FTE		$ 177,688.98		$ 122,089.40		$ 201,955.85	$ 178,482.67			
Total operating cost	$ 301,942.00		$ 732,240.00		$ 2,490,075.00			$ 552,984.00		
Total operating cost/visit	$ 49.80		$ 46.87		$ 61.15			$ 49.70	$ 63.80	
Total operating cost/MD FTE	$ 328,678.38	$ 330,297.22	$ 221,593.57	$ 229,657.57	$ 329,870.44	$ 321,005.82	$ 291,632.27	$ 266,462.59	$273,724.00	$245,661.00
Other Operating costs										
Other costs/MD FTE		$ 128,075.00	$ 104,228.36	$ 104,228.36	$ 158,317.35	$ 158,317.35	$ 140,567.14			
Total medical revenue after operating cost	$ 84,047.00		$ 667,158.00		$ 1,188,339.03			$ 295,334.00		
Ttl med. Rev after operating cost/MD FTE	$ 139,504.75	$ 155,654.31	$ 190,190.89	$ 214,485.48	$ 156,149.62	$ 178,439.23	$ 180,719.23	$ 166,789.50	$192,773.00	$190,219.00
Total midlevel cost	$ 66,657.00		$ 82,825.00		$ 149,036.00			$ 81,727.00		
Total midlevel cost/MD FTE	$ 71,480.00	$ 73,766.41	$ 29,890.15	$ 31,842.79	$ 17,675.48	$ 40,985.88	$ 50,292.64	$ 41,639.77		
Total physician cost	$ 116,716.00		$ 511,931.00		$ 1,486,999.00			$ 415,405.50		
Total physician cost/MD FTE	$ 147,160.94	$ 157,212.41	$ 180,107.14	$ 166,162.14	$ 177,229.14	$ 198,546.51	$ 170,411.15	$ 176,361.00	$180,728.00	$145,798.00
Other revenue	$ 35,817.49		$ 11,442.00		$ 150,603.00					
Other revenue/MD FTE	$ 783.85	$ 23,565.37	$ 1,137.38	$ 1,011.55	$ 1,402.13	$ 3,546.55	$ 9,096.62			
Net Practice Income or loss	$ (36,478.50)		$ 22,735.00		$ 35,827.00			$ -		
Net Practice Income or loss/MD FTE	$ (39,415.00)	$ (40,769.99)	$ 8,119.64	$ 16,048.89	$ 1,943.00	$ (11,645.25)	$ (13,887.25)	$ -		
Overhead Rate	68%		49%		60%			62%		
Accounts Receivable										
% of Total AR 0 to 30 days	44.19%		45.66%		56.16%			48.29%	42.61%	41.52%
% of Total AR 31 to 60 days	15.13%		15.29%		13.39%			14.47%	15.28%	16.89%
% of Total AR 61 to 90 days	8.61%		10.39%		6.36%			8.48%	7.90%	9.11%
% of Total AR 91 to 120 days	7.85%		4.76%		4.48%			6.11%	5.35%	6.29%
% of Total AR over 120 days	14.44%		16.44%		18.60%			16.54%	21.69%	26.20%
Total % AR									92.83%	100.01%
B&O as % of Total cost	12.01%		11.63%		9.46%			10.53%	9.09%	
Descriptive Variables										
# of MD FTE	1		3.06		8.65			2.00	5.2	5
# of Provider FTE	2		4.7		10.98			3.48	8	7.25
# of support FTE	4		14.4		41.3			9.00	26.6	26.3
Total support FTE/provider FTE	3.00		2.57		4.09			2.81	3.33	
Total support FTE/MD FTE	3		3.57		6.07			3.57	5.12	4.67
support personnel exp. as % of ttl med.rev.	34.00%		27.00%		36.00%			33.24%	32.24	25.84%
Medicare Encounter Rate	$ 87.07		$ 92.43		$ 111.73			$ 86.76		
Medicaid Encounter Rate										
# of years as RHC	8		3		1.5			6		

Chart 4.6 Cost Structure of RHCs by Number of MDs FTE

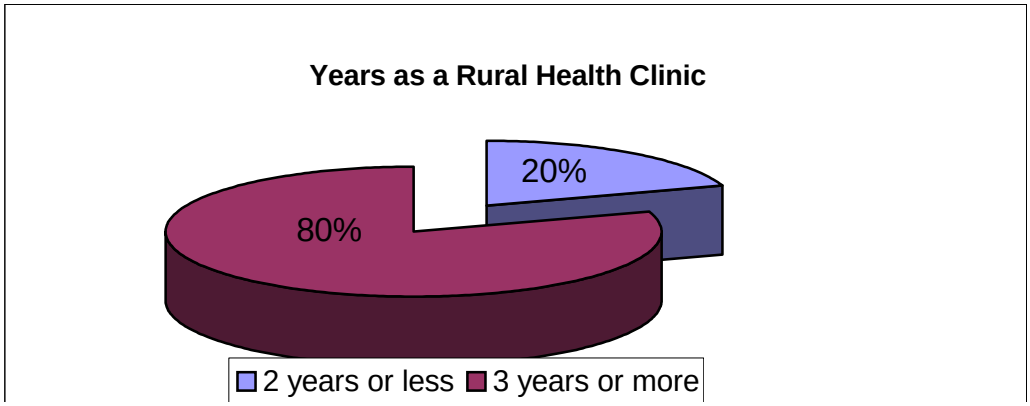


Qualitative Data

Operational Characteristics

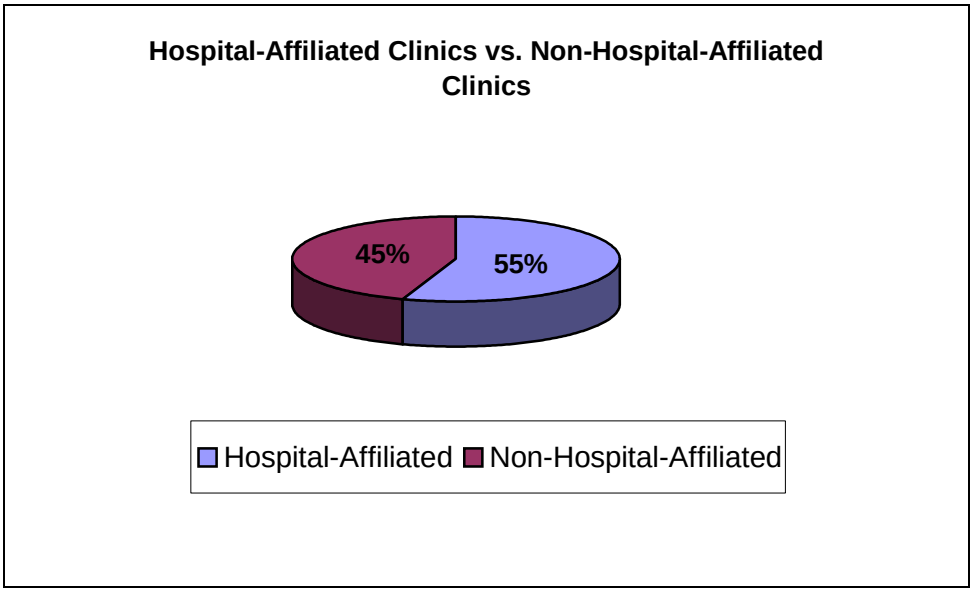
The number of years a clinic had been designated as a Rural Health Clinic ranged from 29 years to 1 year. Eighty percent (80%) have been operating as designated Rural Health Clinics for three years or more and 20% have been operating as designated Rural Health Clinics for two years or less.

Chart 5.1 Years as a Rural Health Clinic



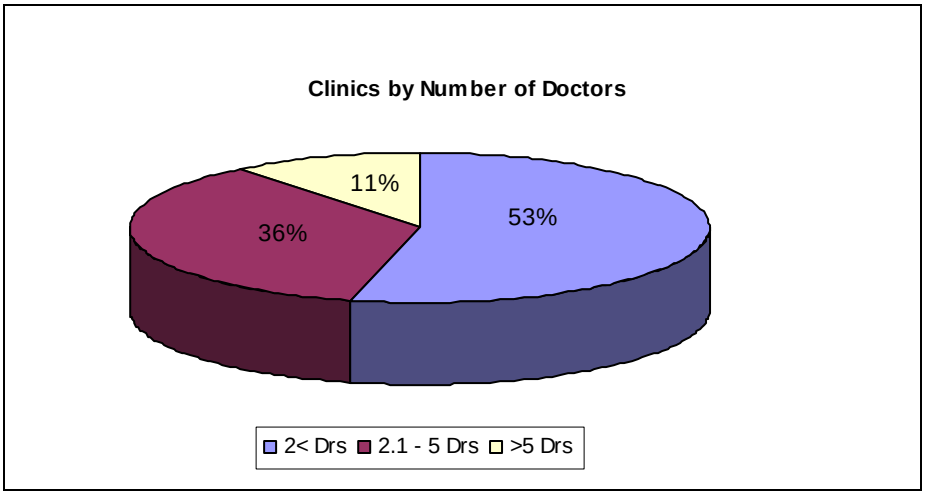
Hospital-Affiliated clinics accounted for 55% of the total clinics while Non-Hospital-Affiliated clinics accounted for 45%.

Chart 5.2 Hospital-Affiliated Clinics vs. Non-Hospital-Affiliated Clinics



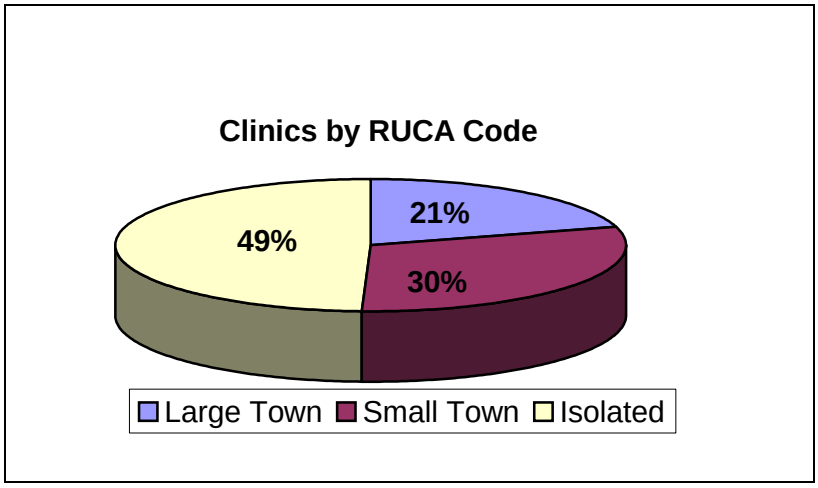
Fifty-three percent (53%) of all clinics employed less than two doctors including six clinics which did not have a doctor on staff. Thirty-six percent (36%) employed 2.1-5 doctors, and 11% employed more than 5 doctors.

Chart 5.3 Clinics by Number of Doctors



Forty-nine percent (49%) of the total clinics were located in isolated areas as defined by the RUCA Codes. Of the remaining clinics, 30% were in small towns and 21% were in large towns.

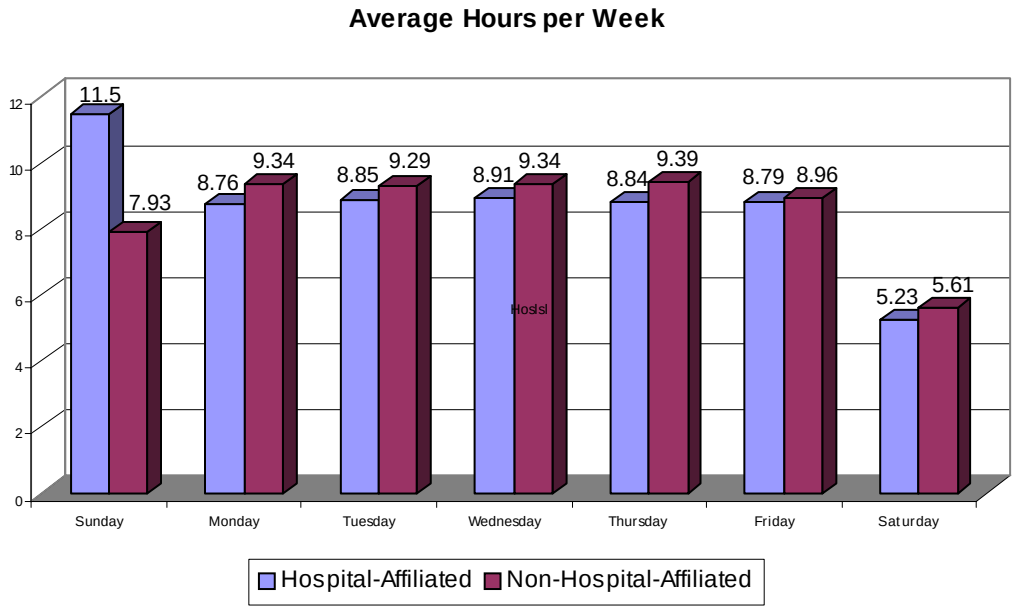
Chart 5.4 Clinics by RUCA Code



Days & Hours of Operation

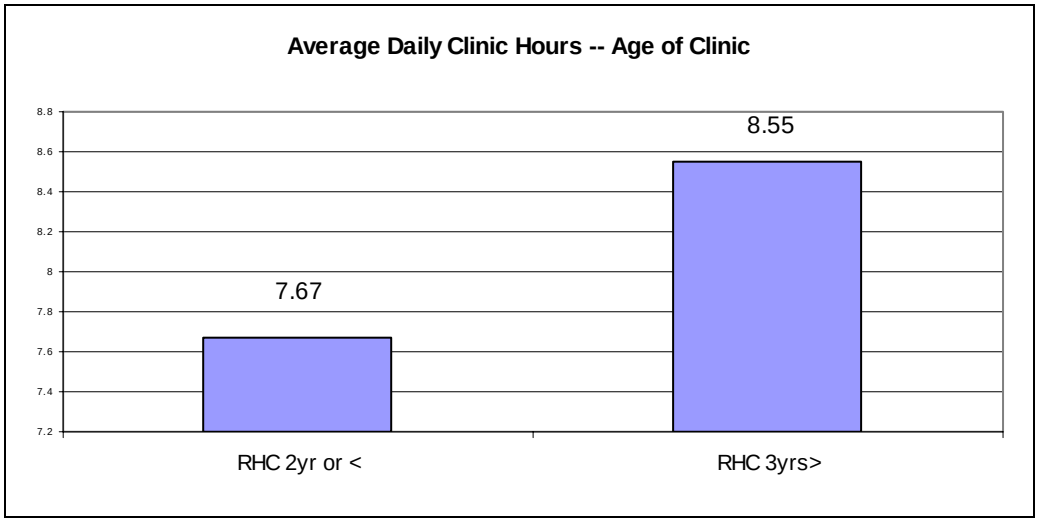
Many Rural Health Clinics are open seven days per week and most days they are open an average of at least eight hours.

Chart 5.5 Average Hours per Week



Clinics that have been in operation three years or more are open an average of 8.55 hours per day in contrast to 7.67 hours per day for clinics less than two years old.

Chart 5.6 Average Daily Clinic Hours – Age of Clinic



There is not a lot of difference in hours as you look at Hospital-Affiliated versus Non-Hospital-Affiliated, but average hours in large towns are about an hour longer than in isolated areas. The size of the clinic definitely matters. Those clinics with five or more doctors are able to provide service an average of 9.6 hours compared to 8.4 in clinics that have two or less doctors.

Chart 5.7 Average Daily Clinic Hours – Hospital-Affiliated / Non-Hospital-Affiliated

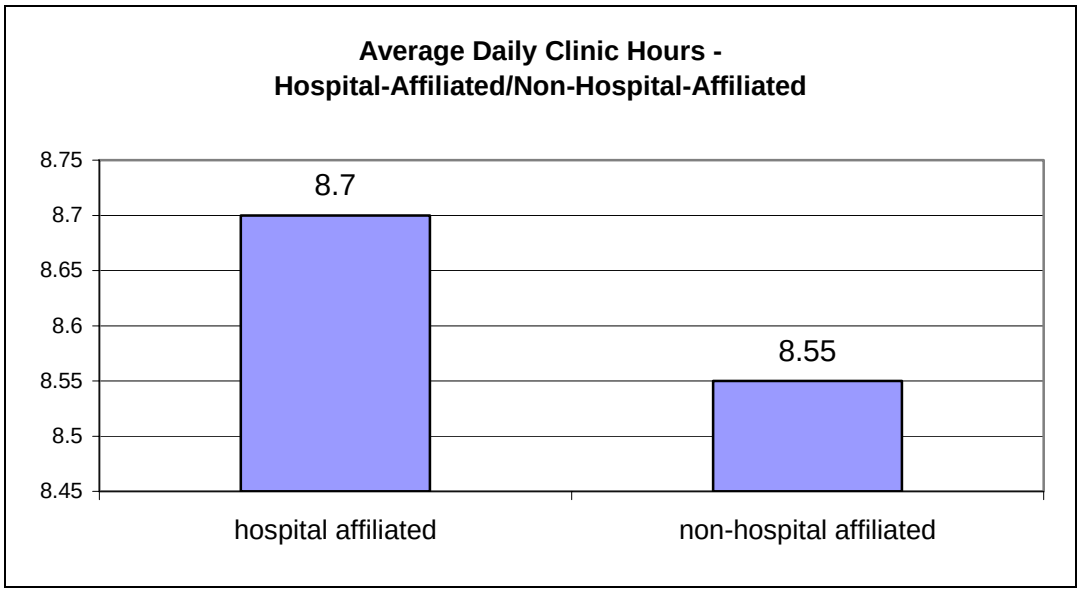


Chart 5.8 Average Daily Clinic Hours - RUCA

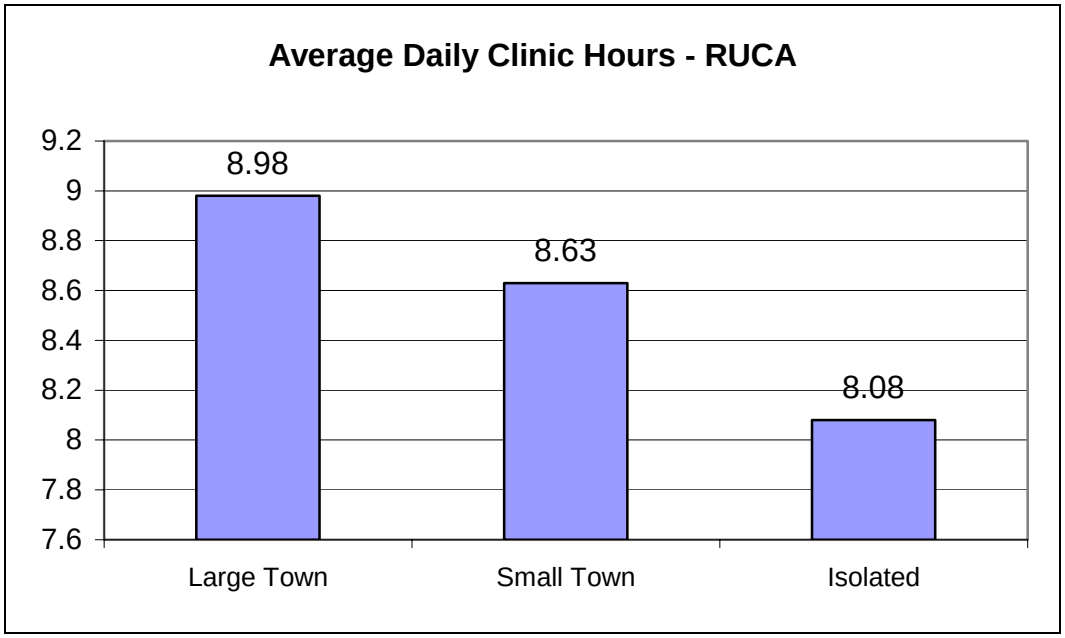
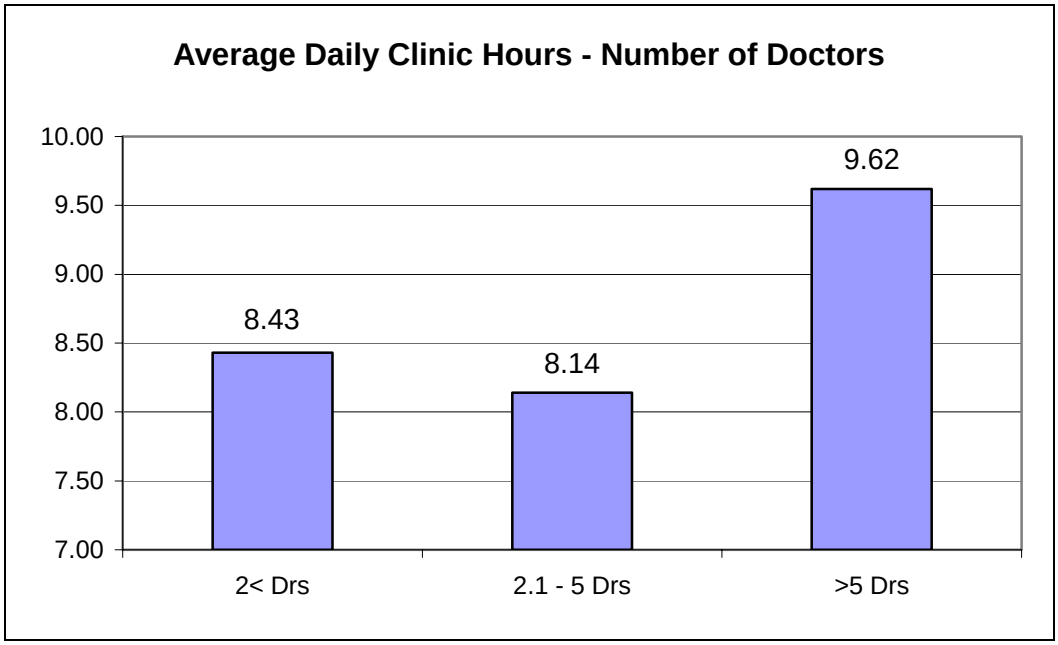


Chart 5.9 Average Daily Clinic Hours - Number of Doctors

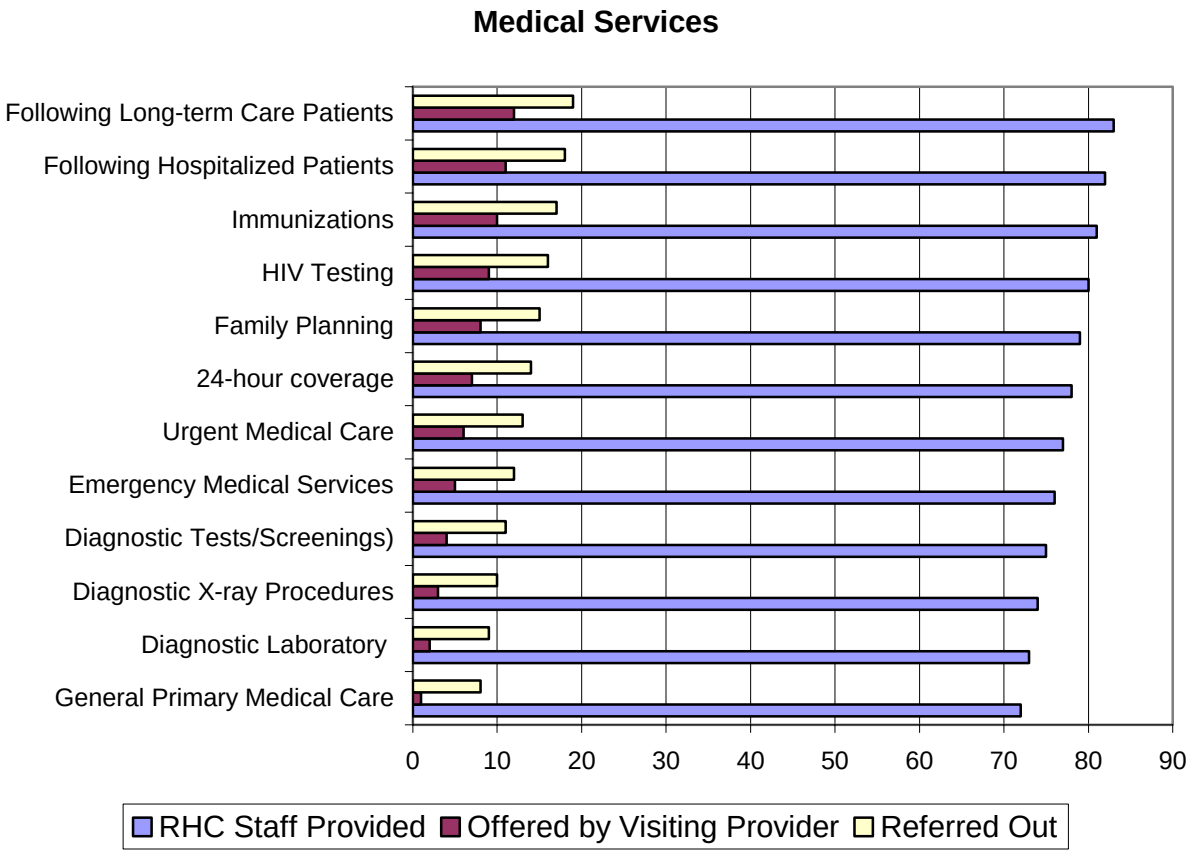


Services

Clinics were asked to fill out a list of services that could be provided by an RHC, checking how they dealt with each service. Options were given to check services as: (1) provided by RHC staff, (2) offered in the RHC by a visiting provider, or (3) referred out to another provider or agency.

Medical Services

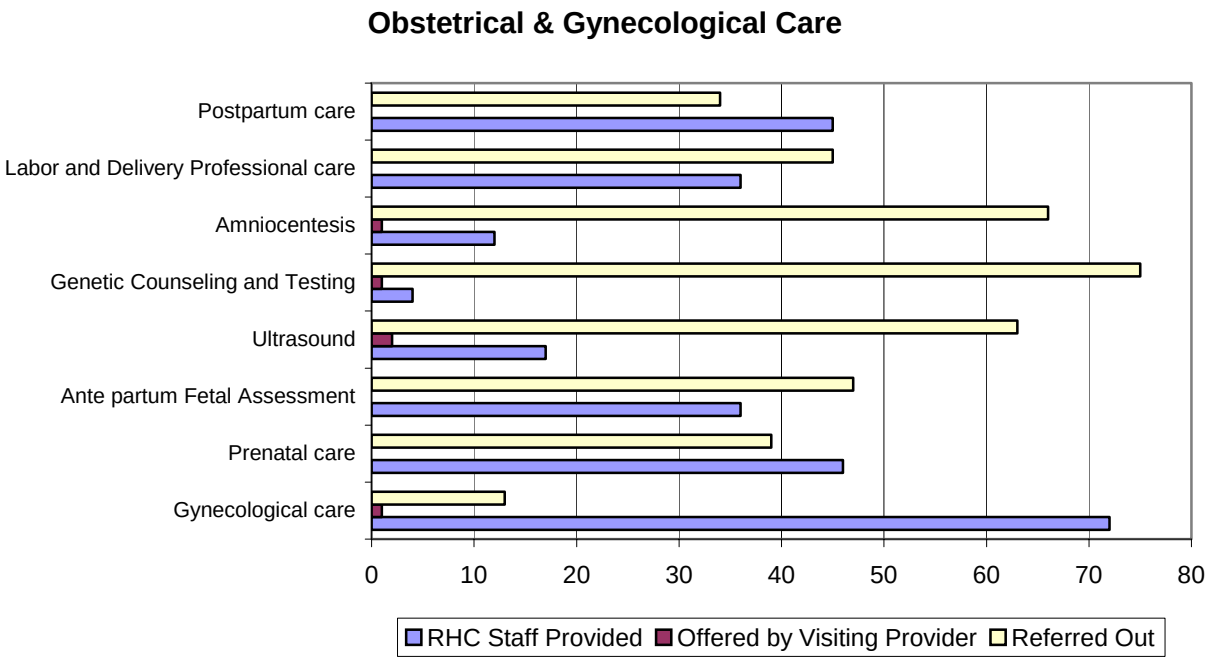
Chart 5.10 Medical Services



Obstetrical and Gynecological Care

The survey and checklist of services was completed during the summer of 2003. Later that year, liability insurance companies advised providers that if they provided prenatal care at all they would have to purchase full obstetrical liability coverage (as if they were actually doing the deliveries). Several providers have ceased doing prenatal care since that time. Some providers also ceased doing deliveries as well due to increased malpractice costs.

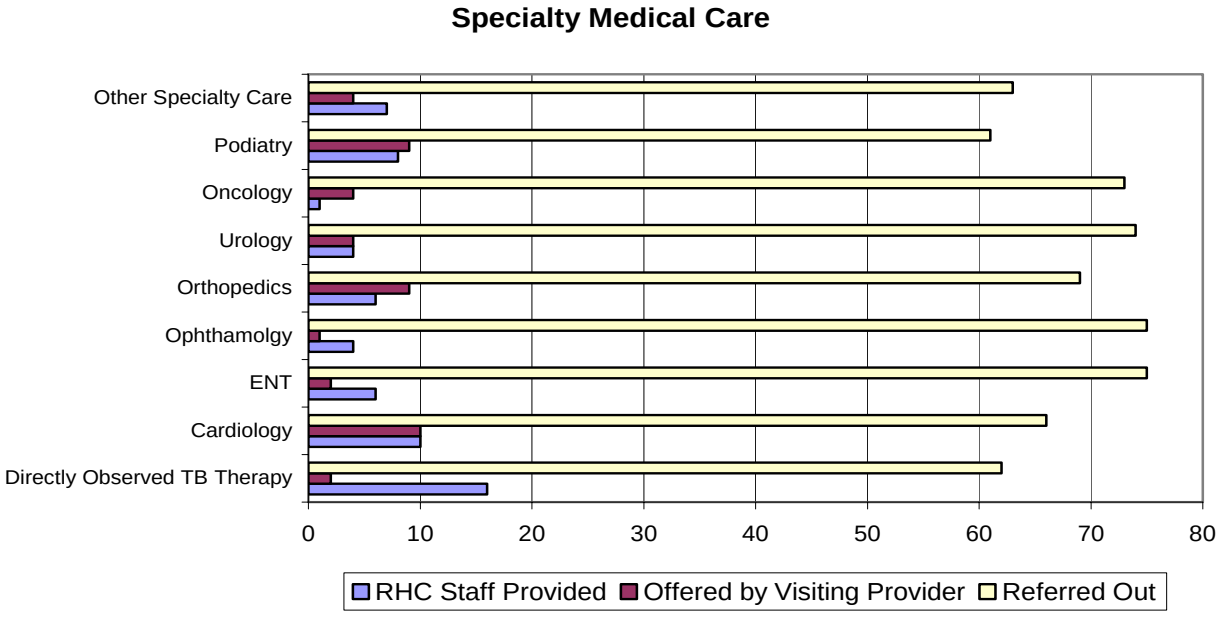
Chart 5.11 Obstetrical & Gynecological Care



Specialty Medical Care

Chart 5.12 reflects the "visiting" specialists that travel out to rural areas, but note that most of this type of care is referred out.

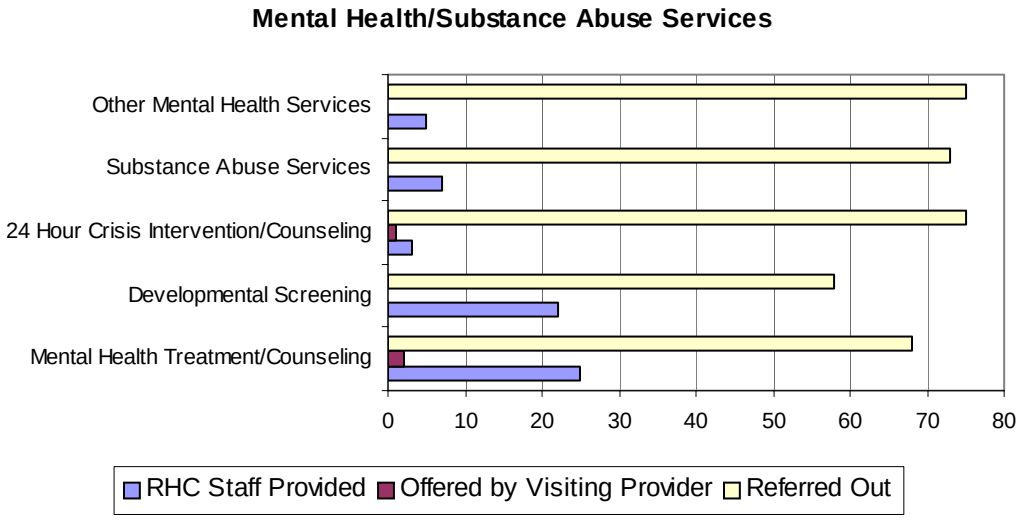
Chart 5.12 Specialty Medical Care



Mental Health Substance Abuse Services

While providers often stated that a large portion of their case load was mental health related, there are few mental health professionals practicing at RHCs in Washington state or providing support services (Chart 5.13)

Chart 5.13 Mental Health/Substance Abuse Services



Other Professional Services

Dental care is another service that can be reimbursed for RHCs, but few are providing this option.

Chart 5.14 Other Professional Services

Other Services

The following charts are other services offered by RHCs.

Chart 5.15 Other Services - I

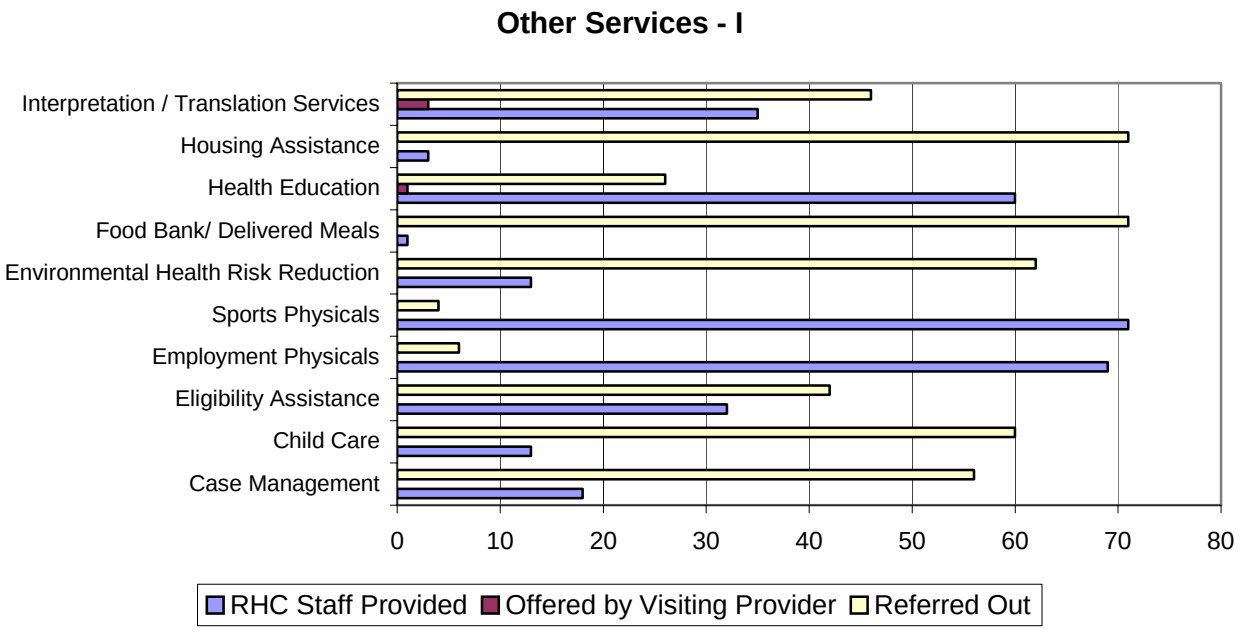
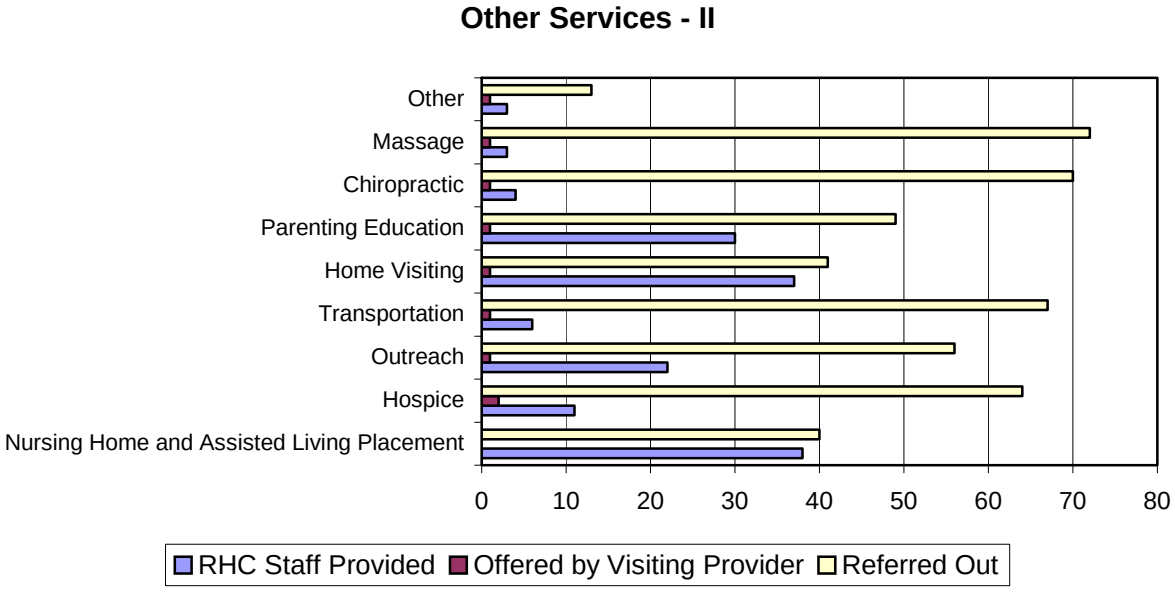


Chart 5.16 Other Services - II



Physical Plant

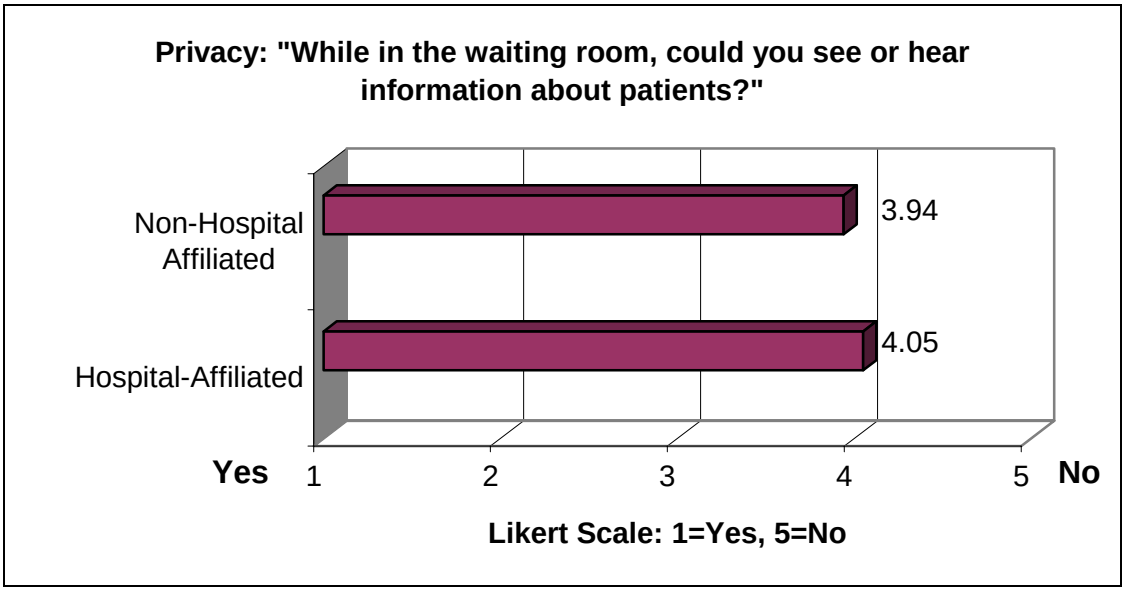
The buildings that house Washington state Rural Health Clinics range in age between 101 years to less than three months, with the average age of the buildings being 26 years.

More than 50% of Washington state RHCs are owned by Public Hospital Districts. As public municipalities, the Public Hospital Districts are limited by law as to the amount of debt they may incur. Because most of the hospital buildings of the Districts were built with Hill-Burton[4] dollars during the 1950's, they are also aged. The need to renovate the hospital plant may compete with the need to renovate or rebuild the clinic.

The surveyors filled out an Observational Survey about each clinic that asked questions about what they saw and heard upon arrival.

Privacy was addressed by the question: "While in the waiting room, could you see or hear information about patients?" On a Likert Scale of 1 (Yes) to 5 (No), the average score was 4.09. The scores for Non-Hospital-Affiliated and Hospital-Affiliated are shown on Chart 5.17. Variations in privacy appeared to be based on the size and layout of the clinic.

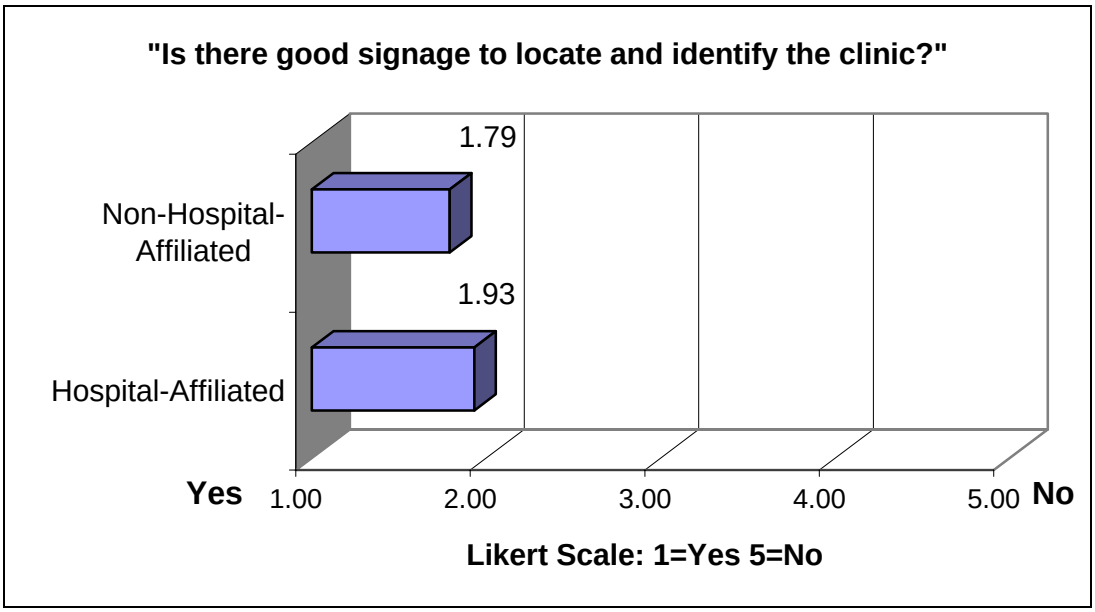
Chart 5.17 Privacy: "While in the waiting room, could you see or hear information about patients?"



[4] Hospital Survey and Construction Act (Public Law 79-725), known as the Hill-Burton Act.

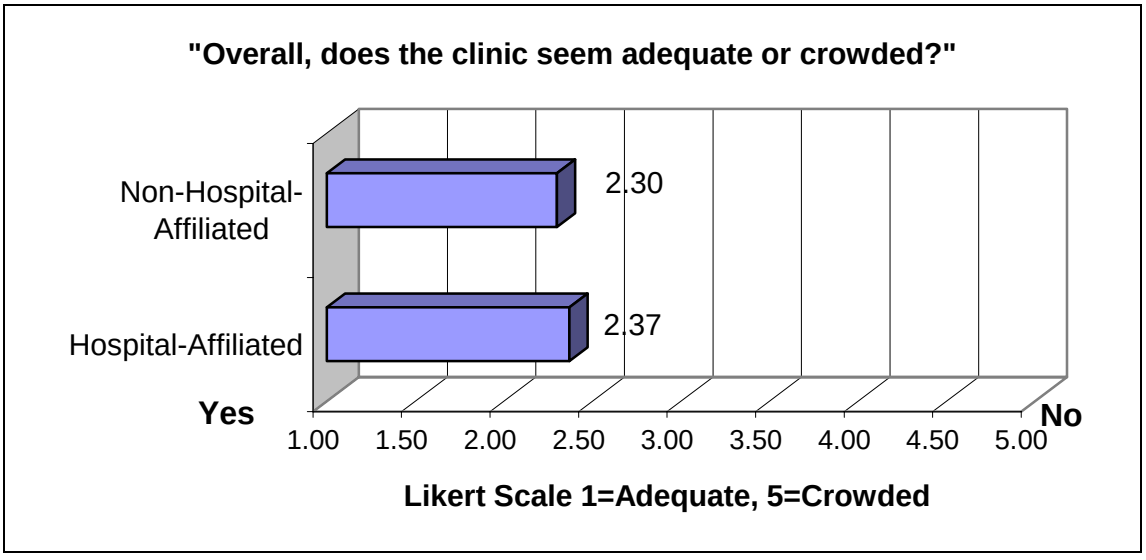
The question "Is there adequate signage to locate and identify the clinic?" yielded an overall average of 2.26 on the Likert Scale of 1 to 5, with 1 being "Yes" and 5 being "No." The scores for Non-Hospital-Affiliated and Hospital-Affiliated are shown on Chart 5.18.

Chart 5.18 "Is there good signage to locate and identify the clinic?"



"Overall, does the clinic seem adequate or crowded?" had an overall score of 2.29 on the Likert Scale, with 1 being "adequate" and 5 being "crowded." The rankings for Non-Hospital-Affiliated and Hospital-Affiliated clinics are shown on the following chart.

Chart 5.19 "Overall, does the clinic seem adequate or crowded?"



Staffing and Recruitment

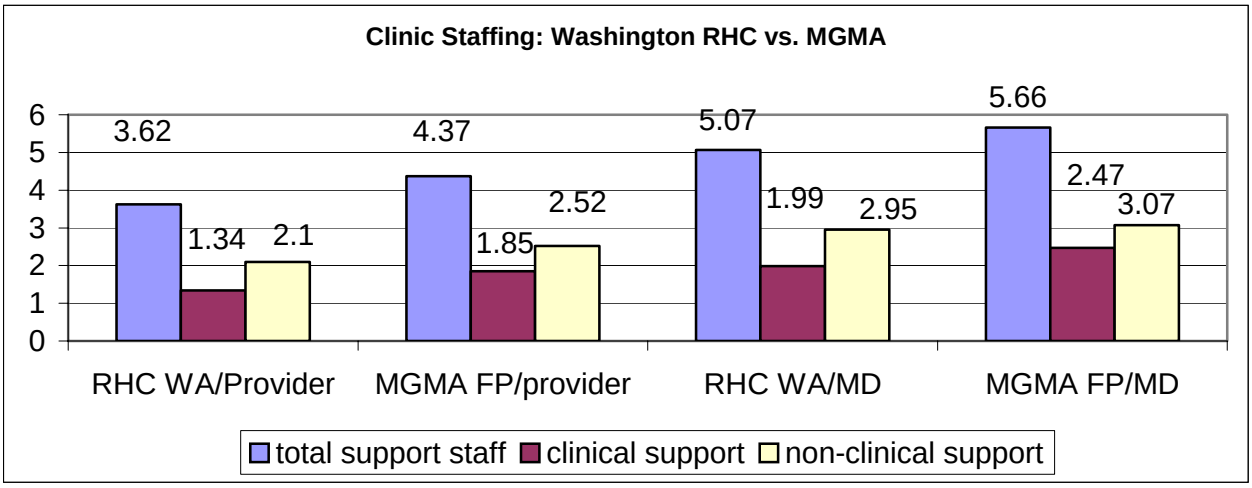
Staffing Patterns

Overall Staffing for Washington RHCs differs quite a bit from MGMA benchmarks. In general, MGMA FP U.S. utilizes more staff in their clinics than do RHCs in Washington.

Physicians

Staffing patterns were analyzed using the Hospital-Affiliated and Non-Hospital-Affiliated variables. Total staffing/provider for Washington RHCs was 3.62 compared to MGMA staffing/provider of 4.37. Washington RHC staff/MD was 5.07 compared to MGMA staff/MD of 5.66.

Chart 6.1 Clinic Staffing: Washington RHC vs. MGMA



In both types of clinics, family practice physicians comprised three-quarters of the physician staff (72% HA, 74% non-HA). At the HA clinics, physicians practicing family practice with OB comprised 9% and pediatricians were 10% of the employed physicians at independent clinics.

Chart 6.2 Hospital-Affiliated Clinic Physician Type

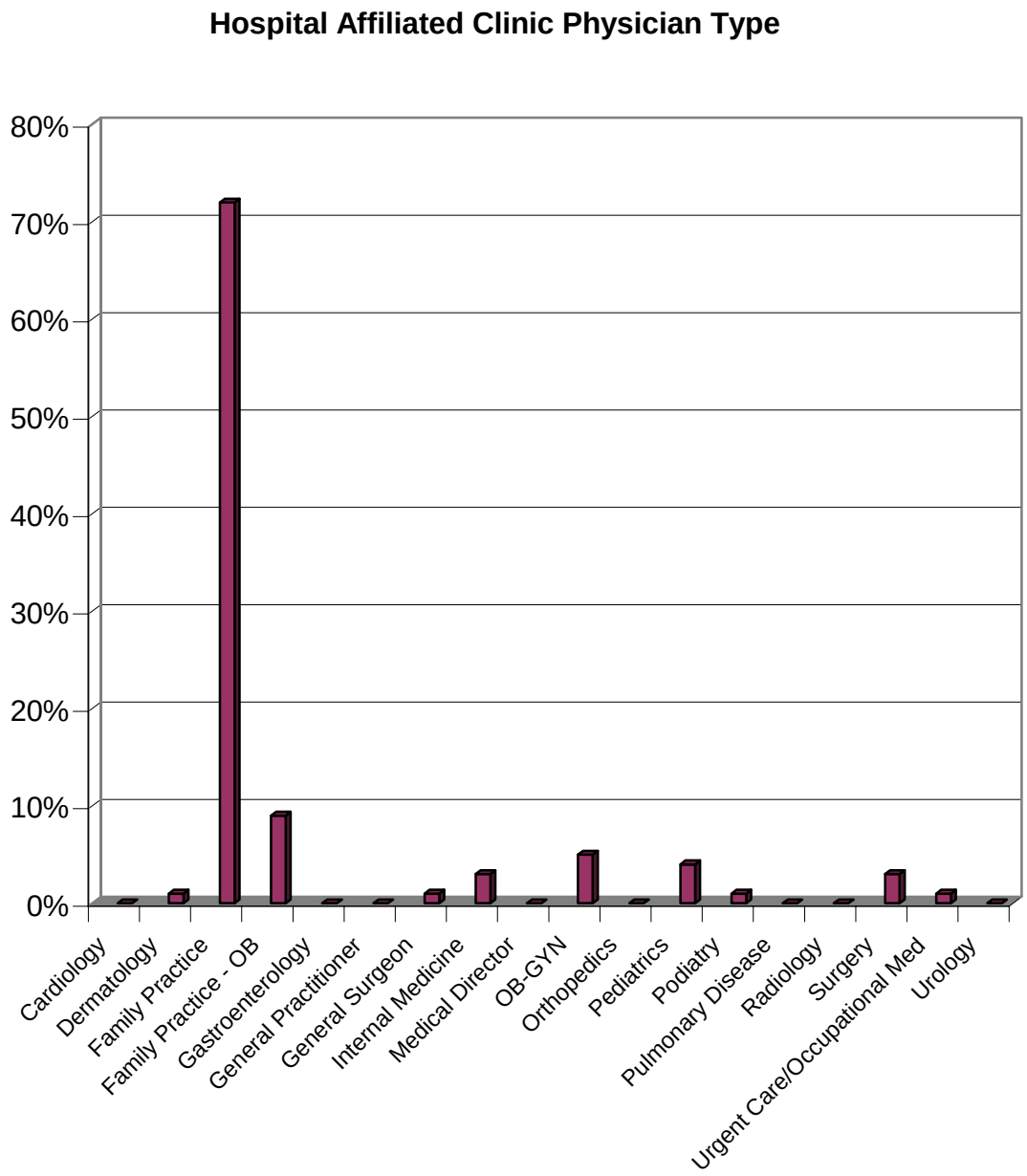
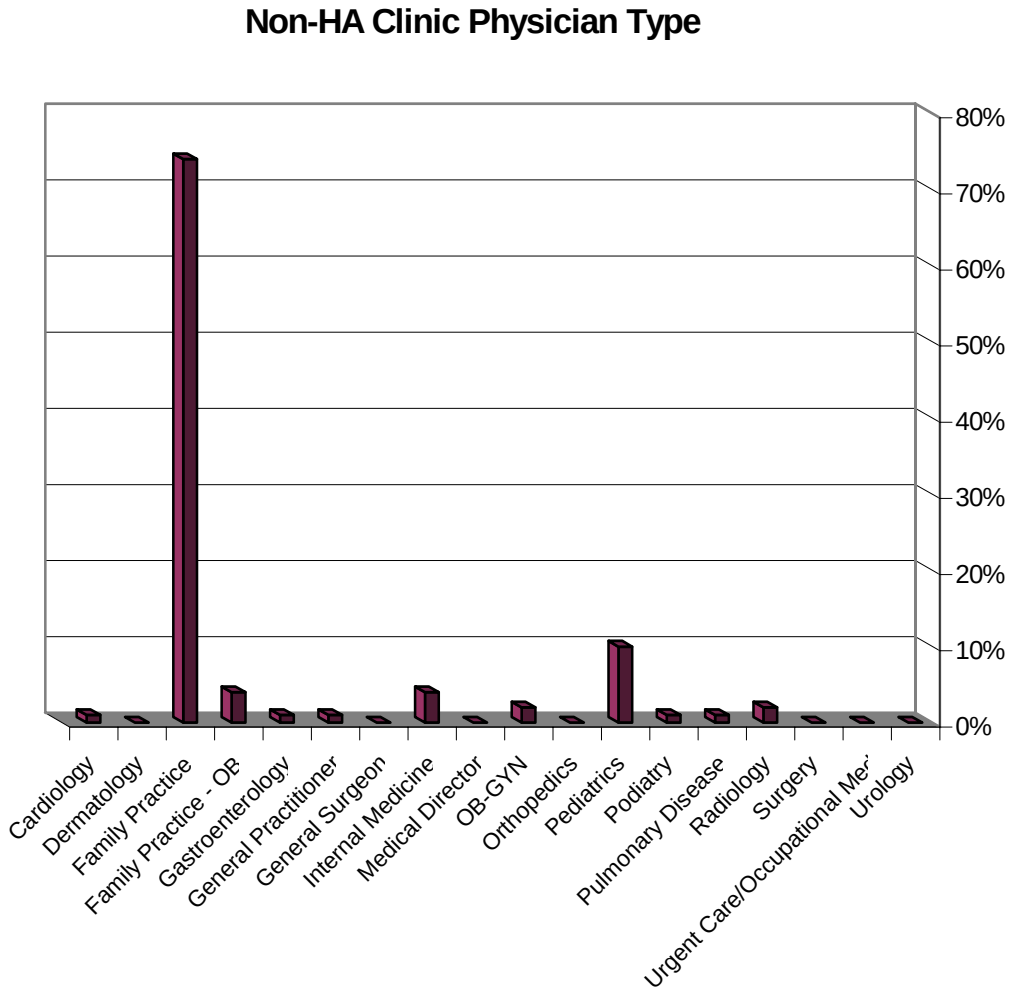


Chart 6.3 Non-Hospital-Affiliated Physician Type



Clinical Support Staff

Registered nurses and licensed practical nurses comprised 50% of the clinical support staff in HA clinics and 63% of the clinical support staff in non-HA clinics. For clinical staffing, again MGMA staffing was higher than for Washington RHCs. Total clinical support for RHCs in Washington/provider was 1.34 compared to 1.85 for MGMA. The total clinical support staff/MD for Washington RHCs was 1.99 compared to 2.47 for MGMA.

Chart 6.4 Hospital-Affiliated Clinical Support Staff

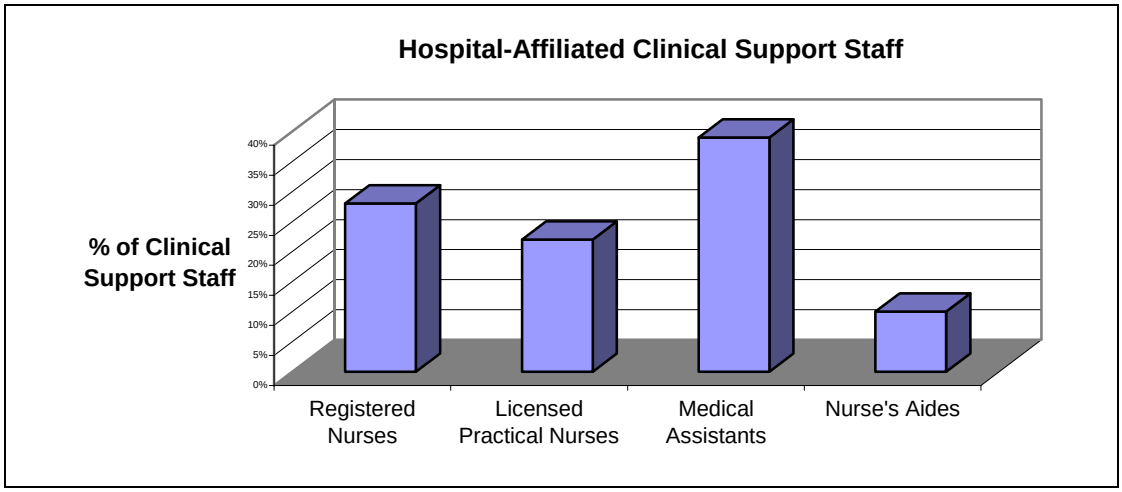
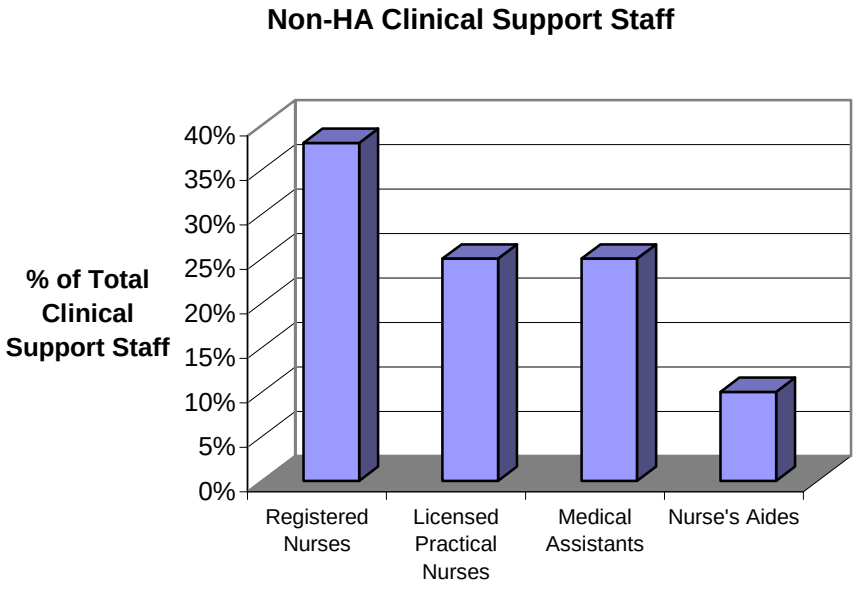


Chart 6.5 Non-Hospital-Affiliated Clinical Support Staff



Non-Clinical Support Staff

In both types of clinics, business office staff and medical receptionists comprised 50% of the non-clinical support staff. The remaining 50% was divided among multiple job descriptions including medical records, managed care administration, clinical laboratory staff, general administration, and housekeeping and maintenance. Non-clinic support paints a similar picture when compared to MGMA figures. Non-clinical support for WA RHCs/provider was 2.10. For MGMA it was 2.52. Non-clinical support for WA RHCs/MD was 2.95 and for MGMA it was 3.07.

Chart 6.6 Hospital-Affiliated Non-Clinical Support Staff

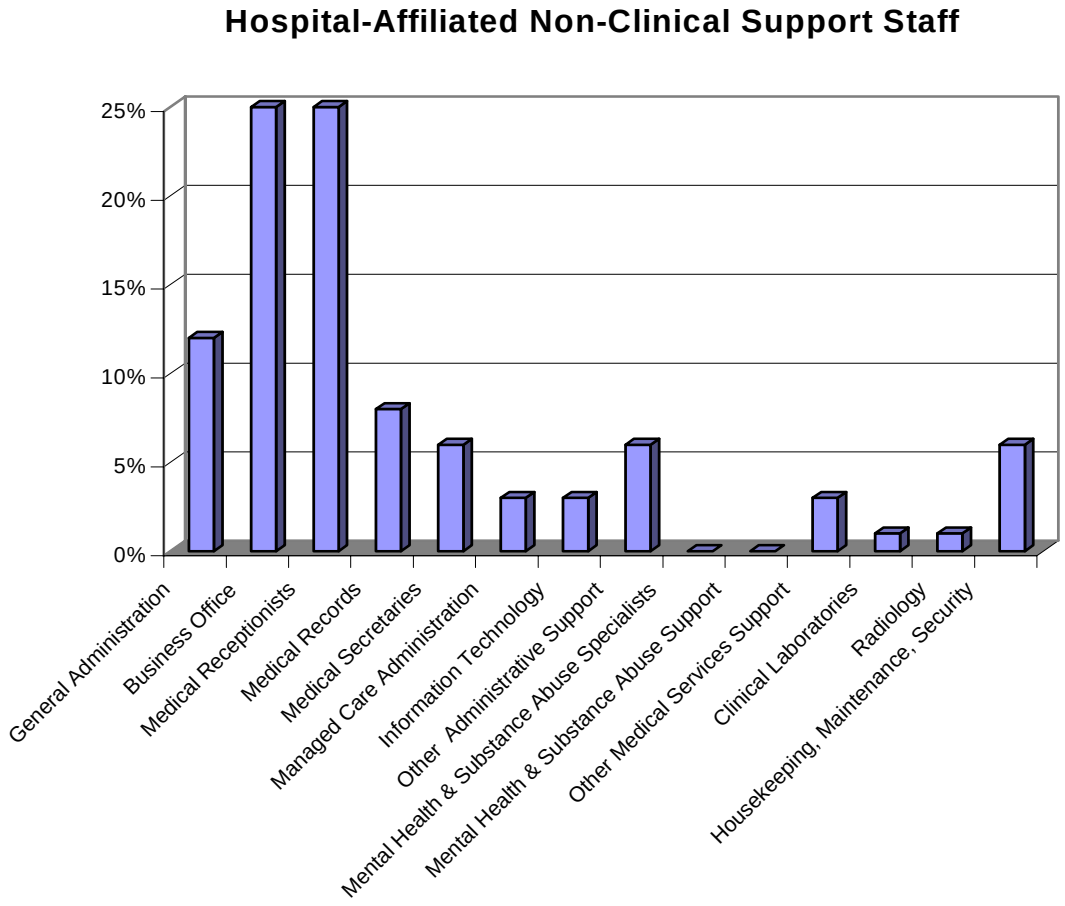
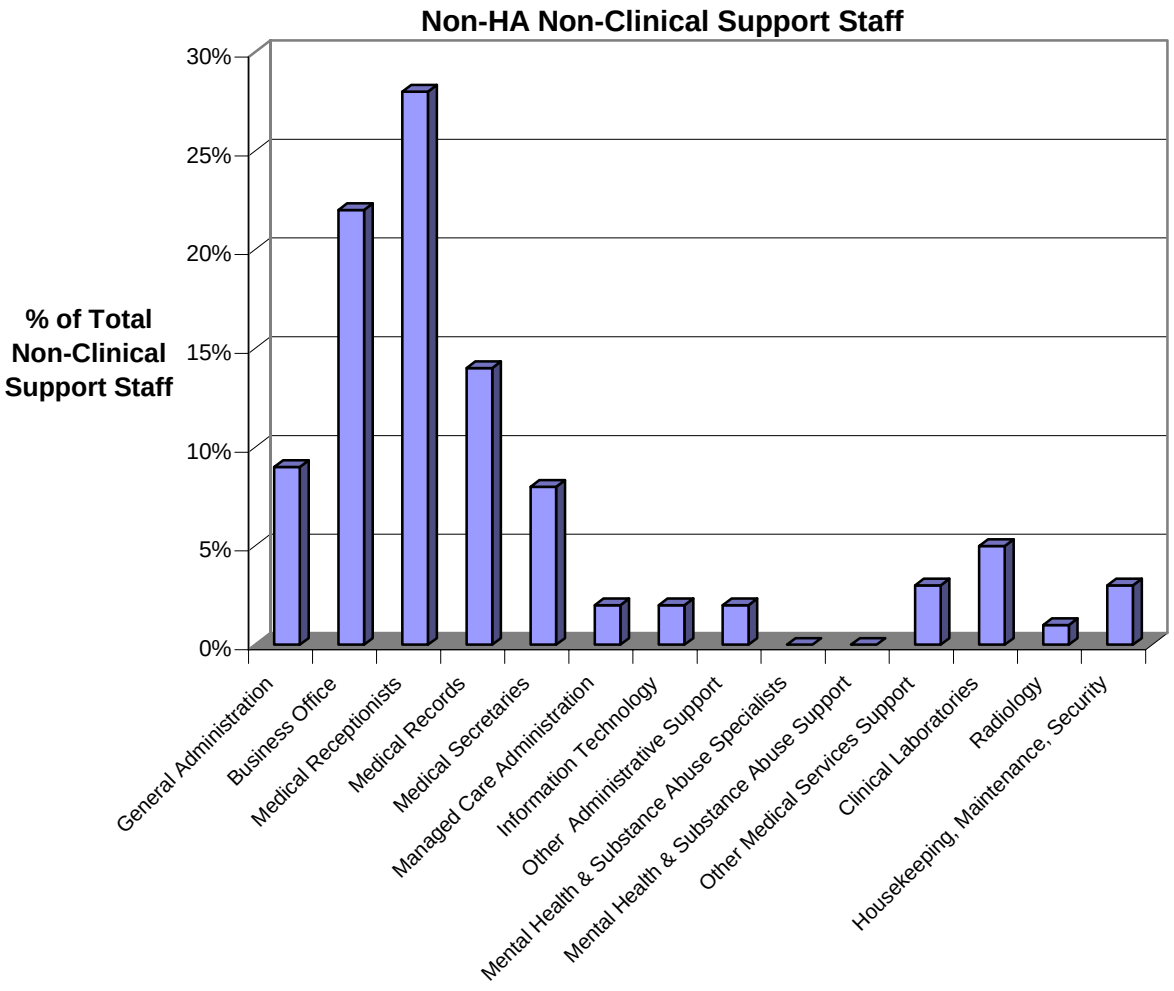


Chart 6.7 Non-Hospital-Affiliated Non-Clinical Support Staff

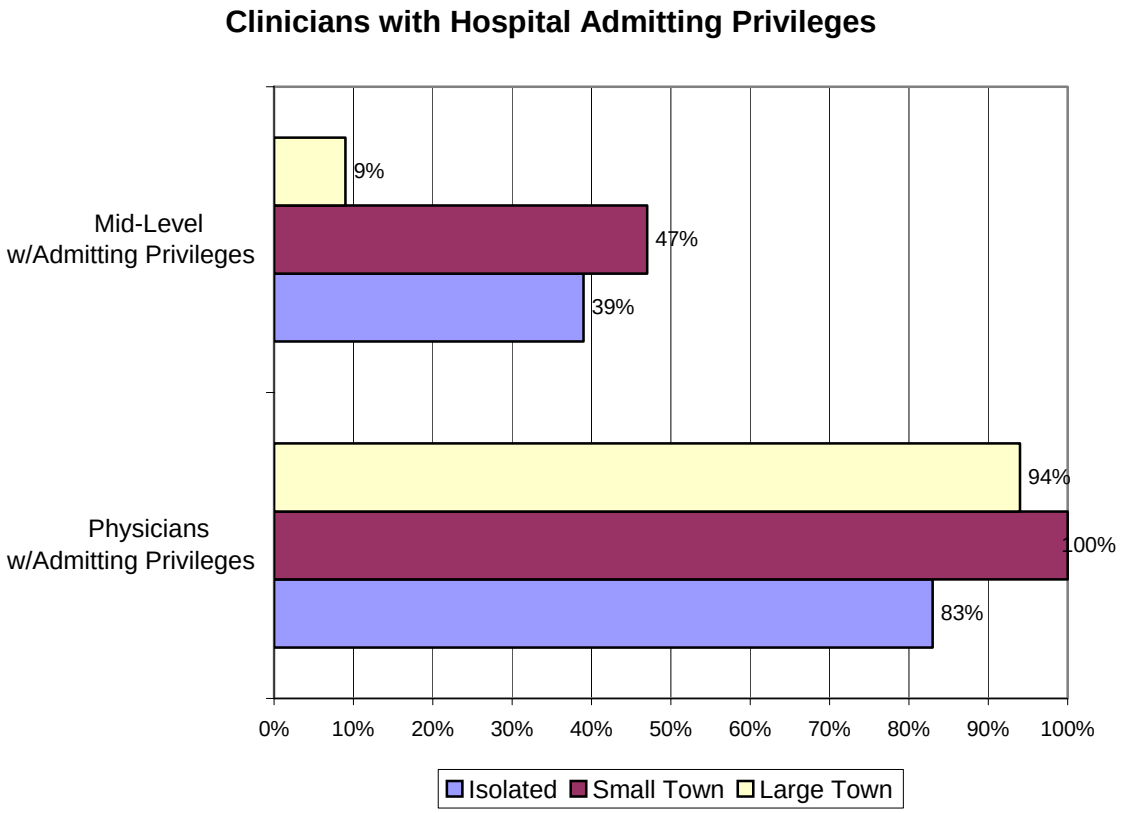


Overall, clinic administrators and providers stated that they were mostly satisfied with the level of staffing.

Hospital Admitting

The majority of physicians in all the clinics had hospital admitting privileges. Mid-level providers in small towns were more likely to have admitting privileges (47%) than mid-levels in large towns or isolated clinics as shown in Chart 6.8.

Chart 6.8 Clinicians with Hospital Admitting Privileges



Hospital Call

Physicians employed in HA clinics were more likely to take call (81%) than physicians employed in Non-HA clinics (66%). Physicians employed in clinics in large (89%) or small towns (81%) were more likely to take call than physicians employed in isolated locations (63%) due to the travel distance to the closest hospital. Physicians employed at clinics with more than 2 physicians were more likely to take call than physicians employed at clinics with 2 or less physicians on staff.

Chart 6.9 Physicians Taking Call – Hospital-Affiliated / Non-Hospital-Affiliated

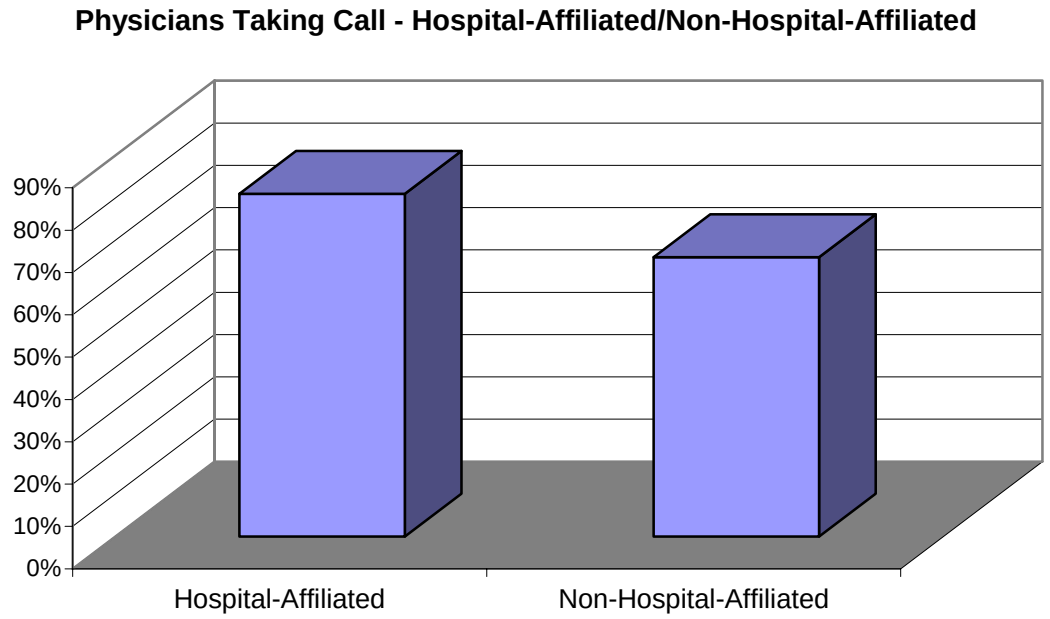


Chart 6.10 Clinicians Taking Hospital Call - RUCA

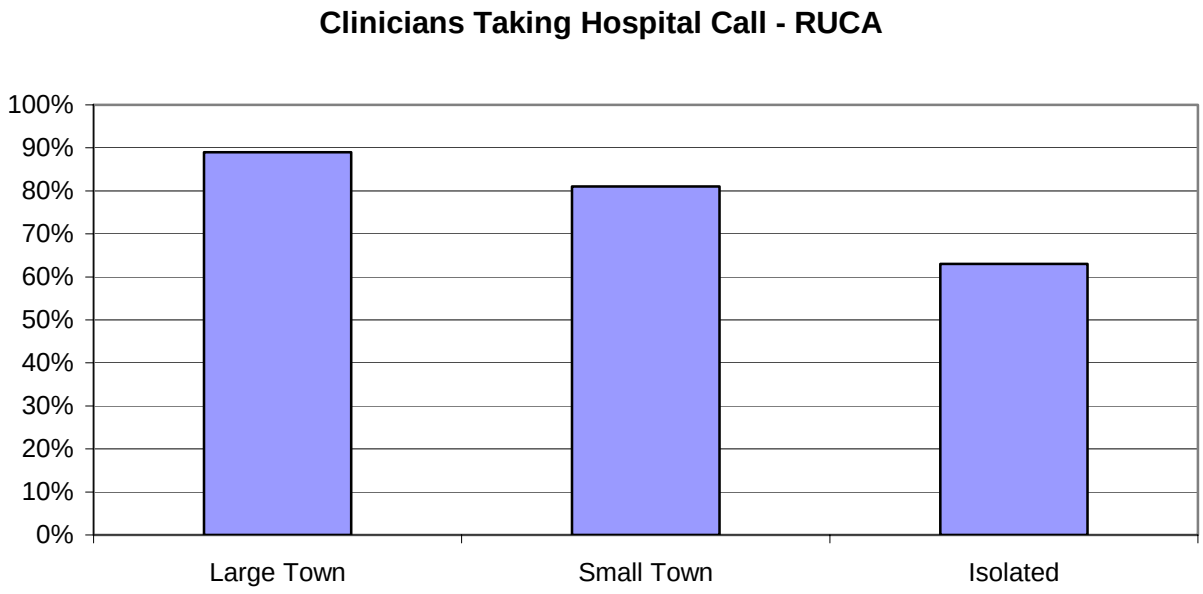
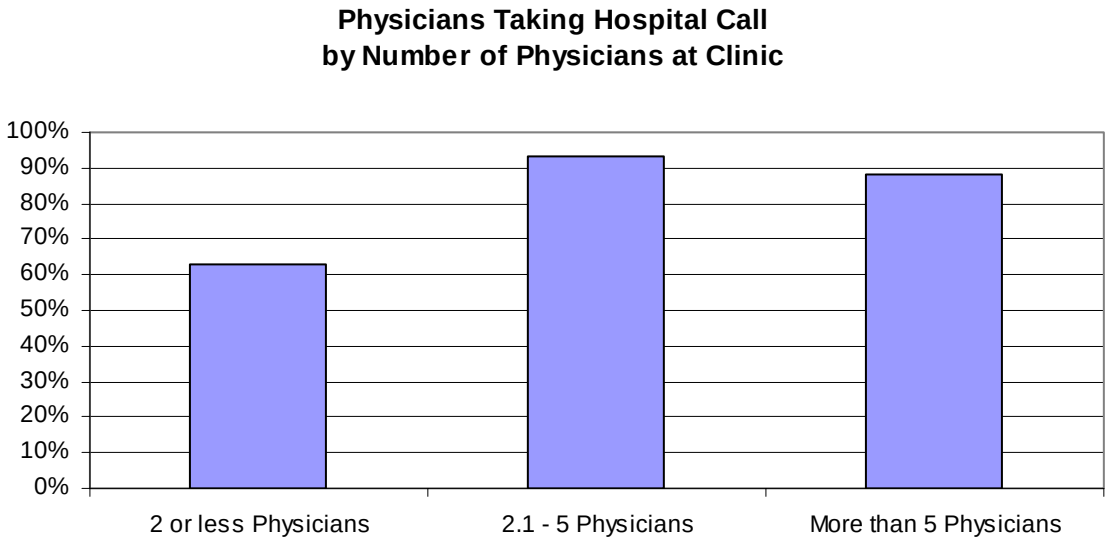


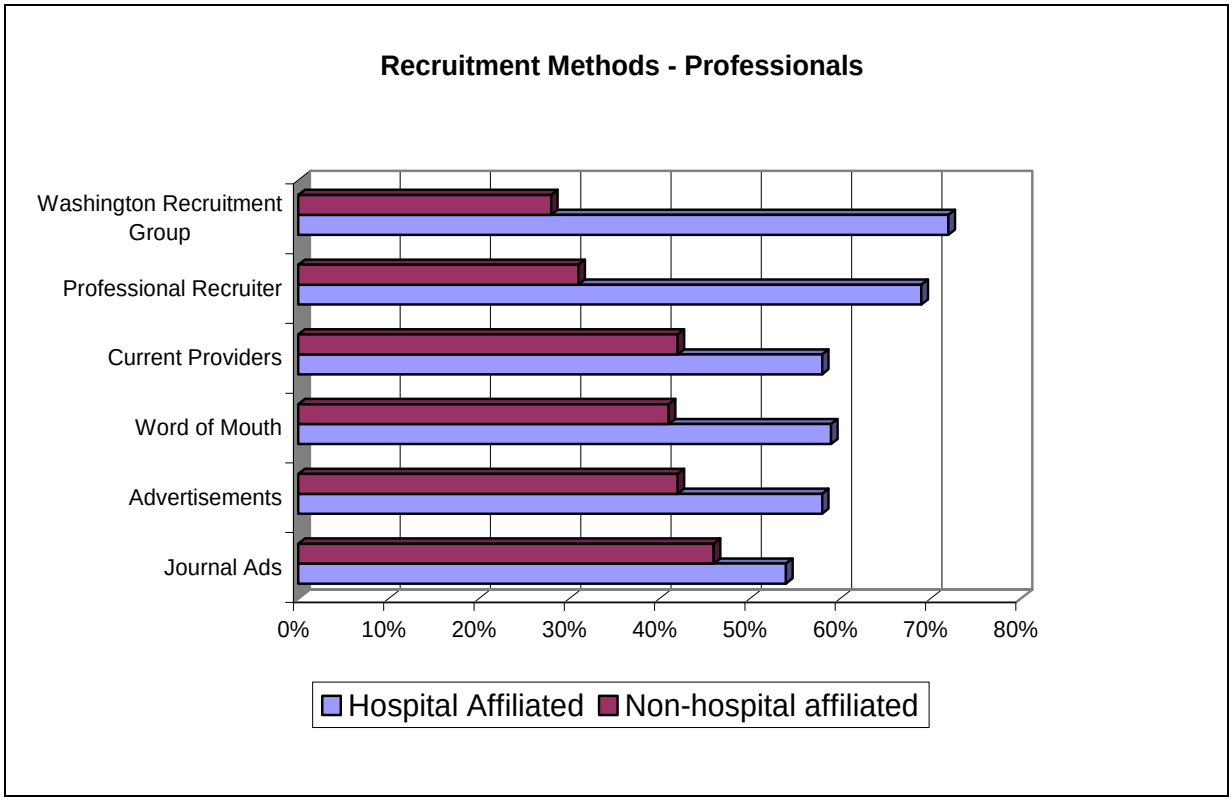
Chart 6.11 Physicians Taking Hospital Call by Number of Physicians at Clinic



Recruitment

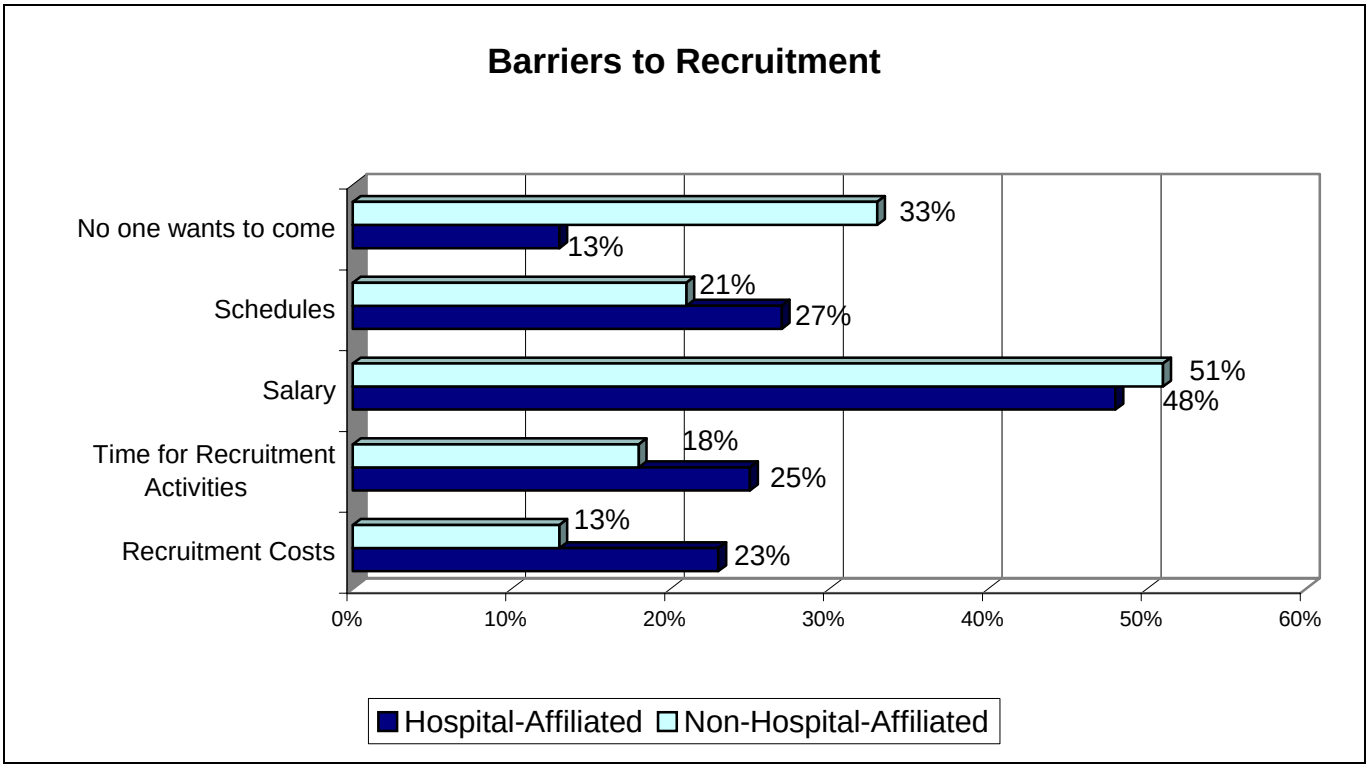
Seventy-two percent (72%) of the HA clinics indicated they use the Washington Recruitment Group for recruiting professionals to their clinics. Other methods of recruitment (professional recruiter, current providers, word of mouth, advertisements and journals) were also used. The non-HA clinics were more likely to use advertisements (42%) and journal ads (46%) over other methods of recruiting. Clinical and non-clinical support was most likely to be recruited through word of mouth and other providers (Chart 6.12).

Chart 6.12 Recruitment Methods - Professionals



Clinics reported the largest barrier to recruitment of professionals was salary. However, the median salary for Washington Rural Health Clinic physicians was $176,361 as compared to the US family physician median salary of $180,728 and the Washington family physician median salary of $145,798. The next most frequent barrier reported by the non-HA clinics was that professionals did not want to come to their location (33%) followed by schedules (21%). The HA clinics reported their most frequent barriers were schedules (27%) and time for recruitment activities (25%) (Chart 6.13).

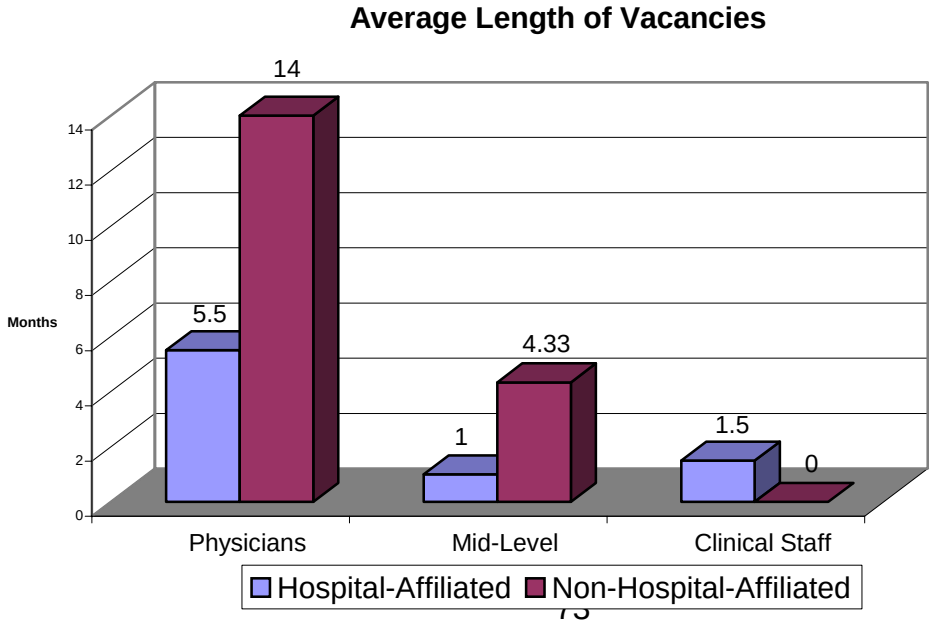
Chart 6.13 Barriers to Recruitment



Vacancies

The average length of vacancies for physicians ranged from 14 months at non-HA clinics to 5.5 months at HA clinics. The average length of vacancies for mid-level providers ranged from 4.3 months at non-HA clinics to 1 month at HA clinics. The average length of vacancies for clinical staff ranged from none at Non-HA clinics to 1.5 months at HA clinics.

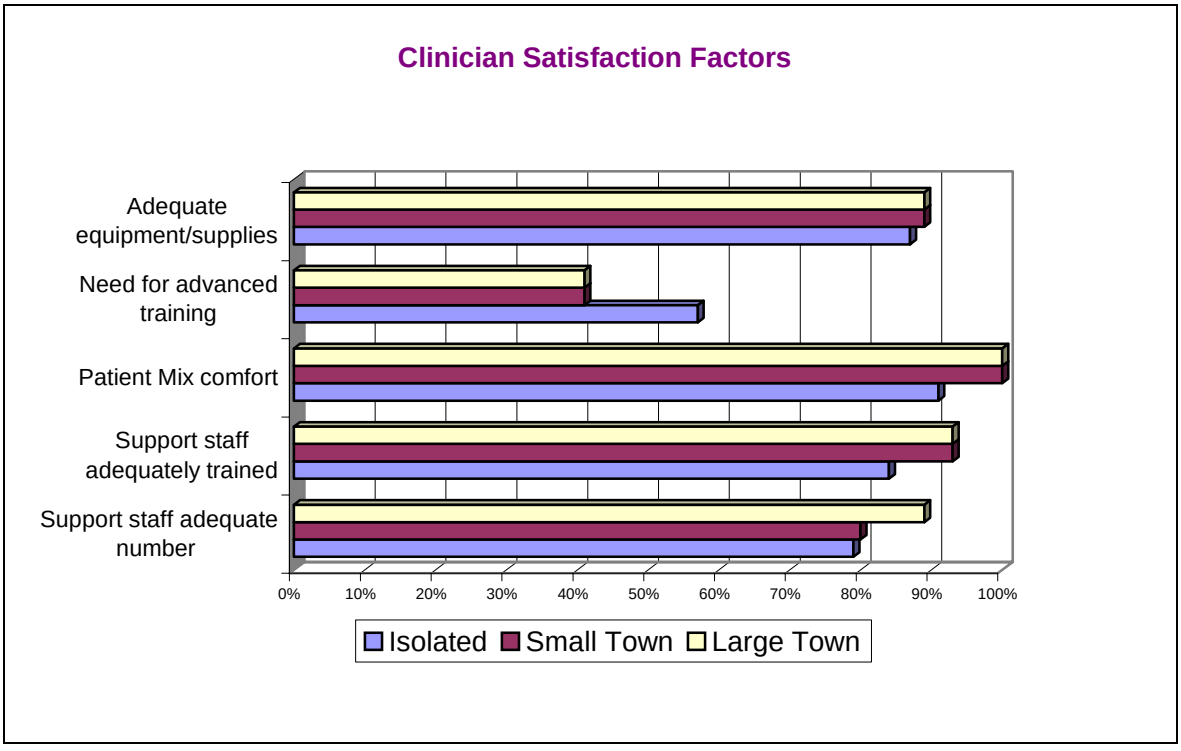
Chart 6.14 Average Length of Vacancies



Provider Satisfaction

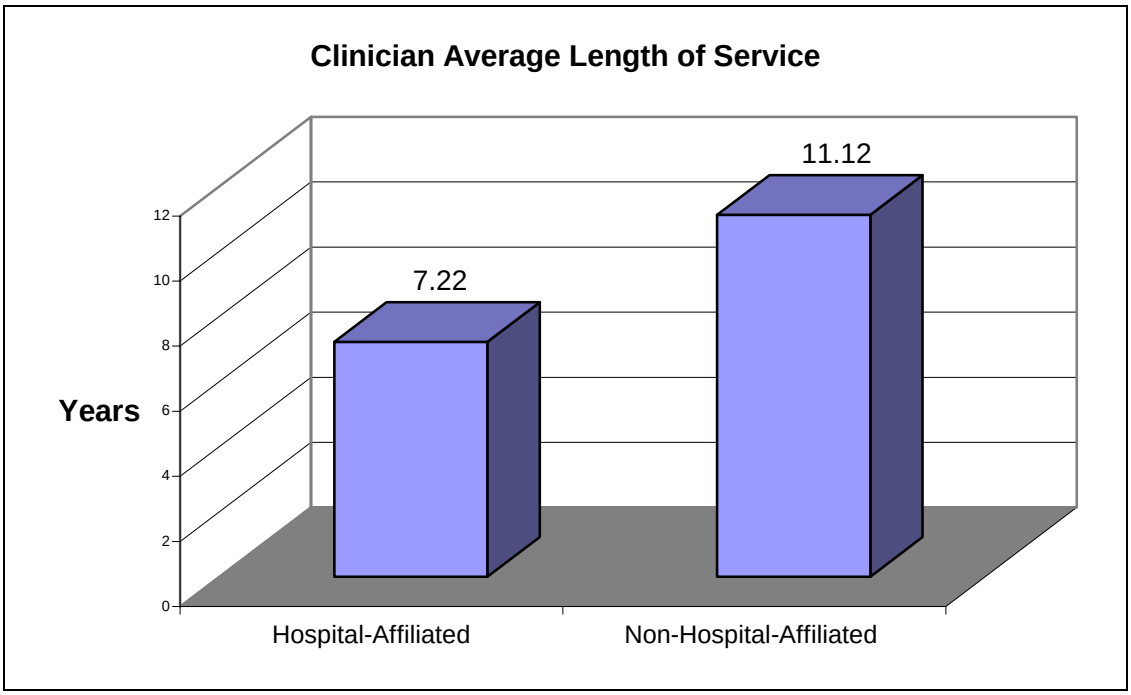
Based on RUCA code analysis, providers generally expressed satisfaction with their working environments, indicating a high comfort level (91-100%) with their patient mix ranging from 91-100%; were satisfied with staff competence and that the staff was adequately trained (84-93%); and, that they had adequate supplies and equipment (87-89%). The providers indicated they felt adequately trained, with only 41-57% indicating they would like to have advanced training. Not all providers indicated the type of advanced training which would be useful; however, areas which were noted were mental health, diabetes and cardiology. Several providers indicated that they would prefer a more complex patient mix on their caseload. The providers also indicated that training for support staff in the areas of billing and coding would be useful (Chart 6.15).

Chart 6.15 Clinician Satisfaction Factors



Clinician length of service averaged 7 years at the HA clinics and 11years at the non-HA clinics indicating a relative high level of satisfaction with the employment environment (Chart 6.16).

Chart 6.16 Clinician Average Length of Service

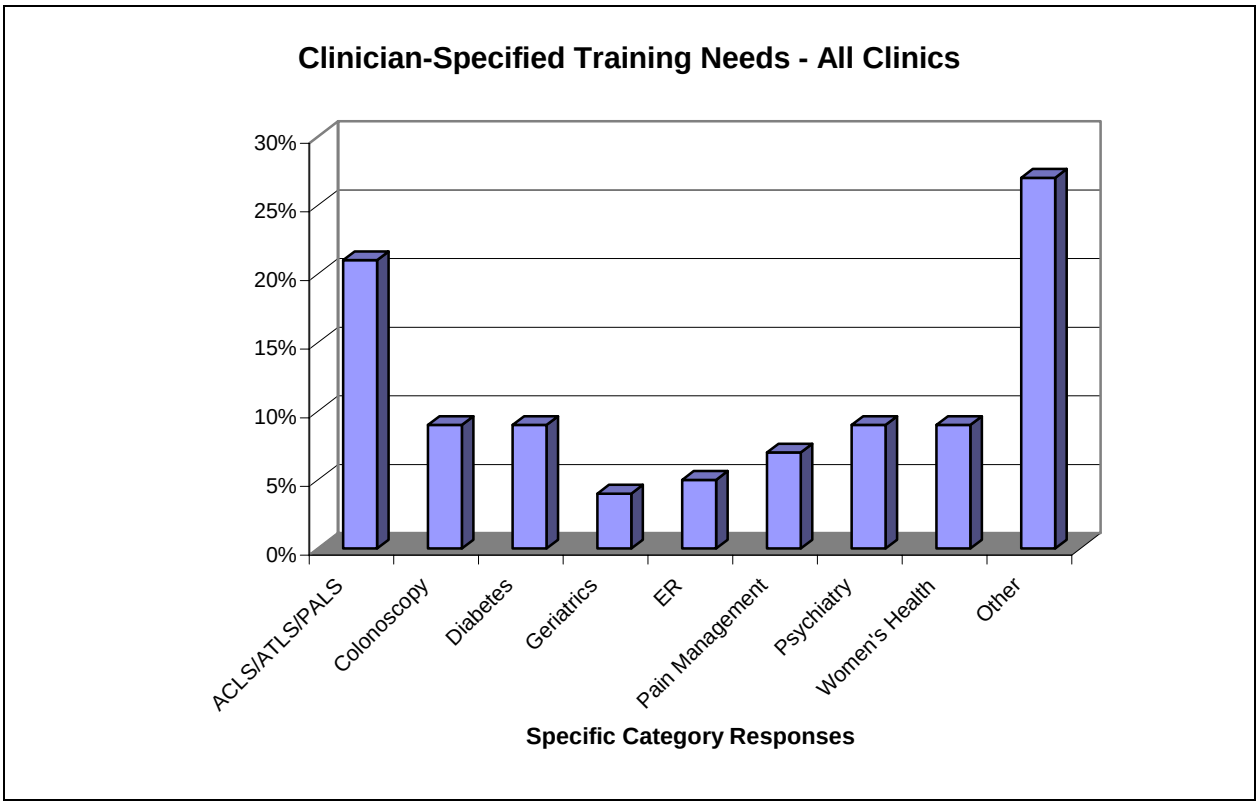


Continuing Education

The clinics were asked about their perceived needs for continuing education for both the clinical staff and the non-clinical staff.

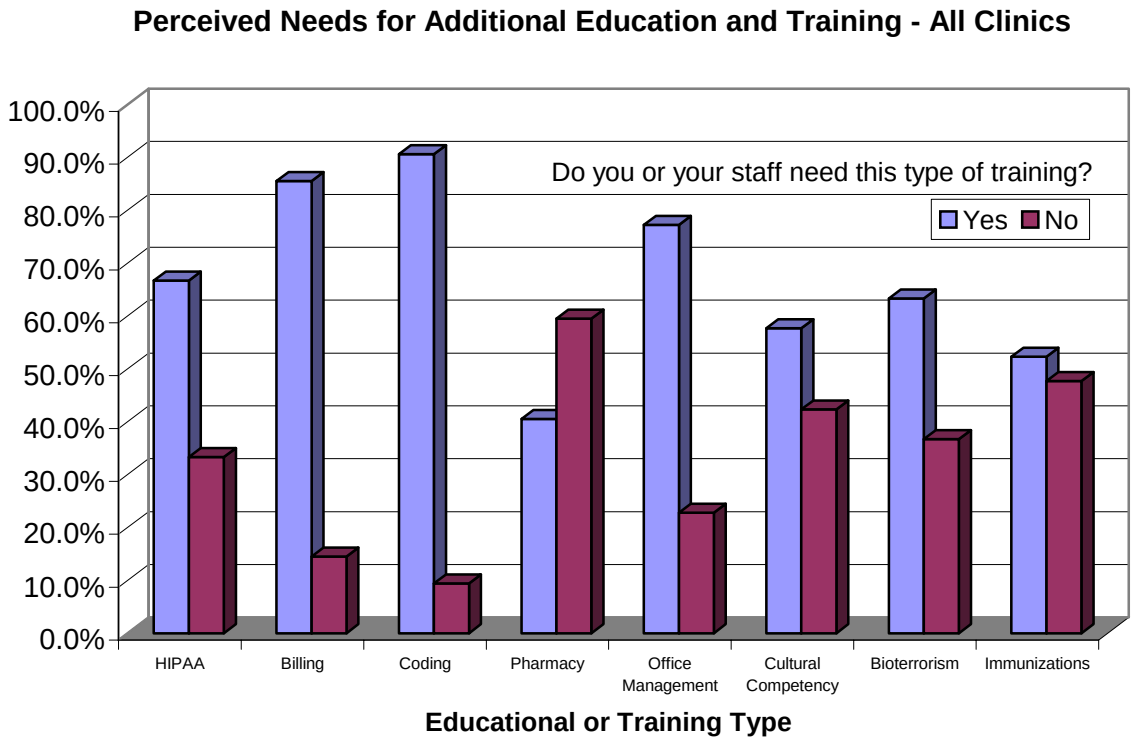
The providers self-identified in the provider interviews the professional areas in which they would like to receive more training. These areas included a wide range of topics including Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS) and Pediatric Life Support (PALS) (21%); colonoscopy (9%); diabetes (9%); psychiatry (9%); and women's health (9%). Providers indicated that obtaining Continuing Medical Education (CME) was a high priority and that they most frequently traveled away from their practices in order to obtain additional training (Chart 6.17).

Chart 6.17 Clinician-Specified Training Needs – All Clinics



The most frequently mentioned need for additional education and training for non-clinical staff was in the area of billing (85.5%) and coding (90.6%) for office staff. Other areas of need included, office management (77%), Health Insurance Portability and Accountability Act (HIPAA) training (67%), bio-terrorism (63%), cultural competency (58%), immunizations (52%), and pharmacy (41%) (Chart 6.18).

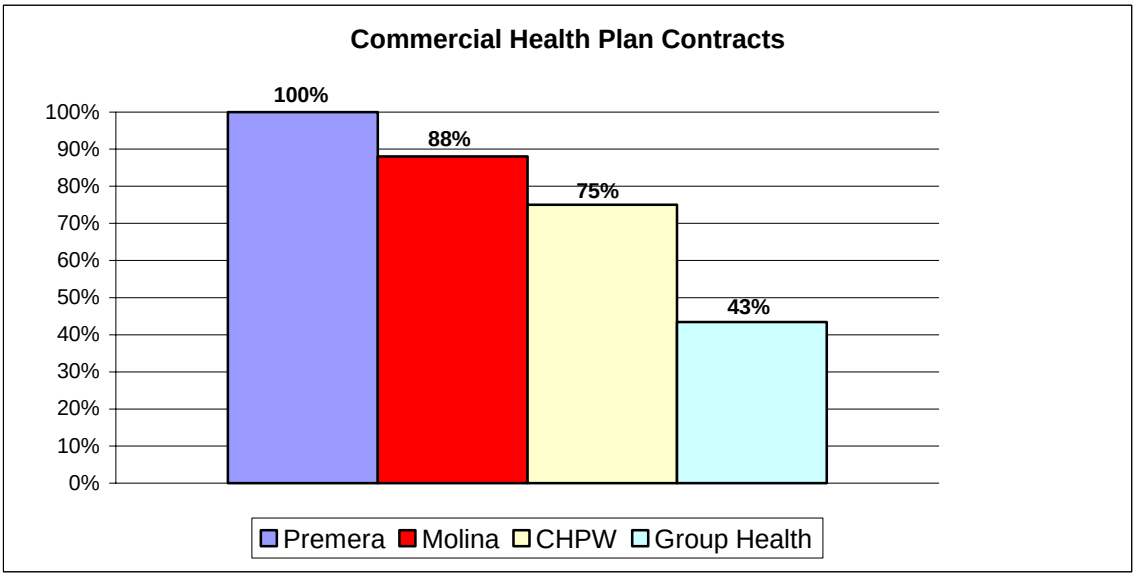
Chart 6.18 Perceived Needs for Additional Education and Training – All Clinics



RHC Contractual Arrangements

Rural Health Clinics have multiple contracts with commercial payers. Premera has the greatest presence with RHCs (100%), closely followed by Molina (88%), and then Community Health Plan of Washington (CHPW, 75%). All of these commercial health plans are in more than 75% of the RHCs (Chart 7.1). CHPW has less of an RHC presence in large towns and Non-Hospital-Affiliated RHCs. Group Health is in 43% of the RHCs, with significantly less of a presence in isolated areas and Hospital-Affiliated clinics. All of the RHCs indicated that they have contracts with additional commercial payers. Other commercial payers that have contracts with RHCs are: Regence, First Choice, Aetna, Uniform, TriCare, and United Healthcare.

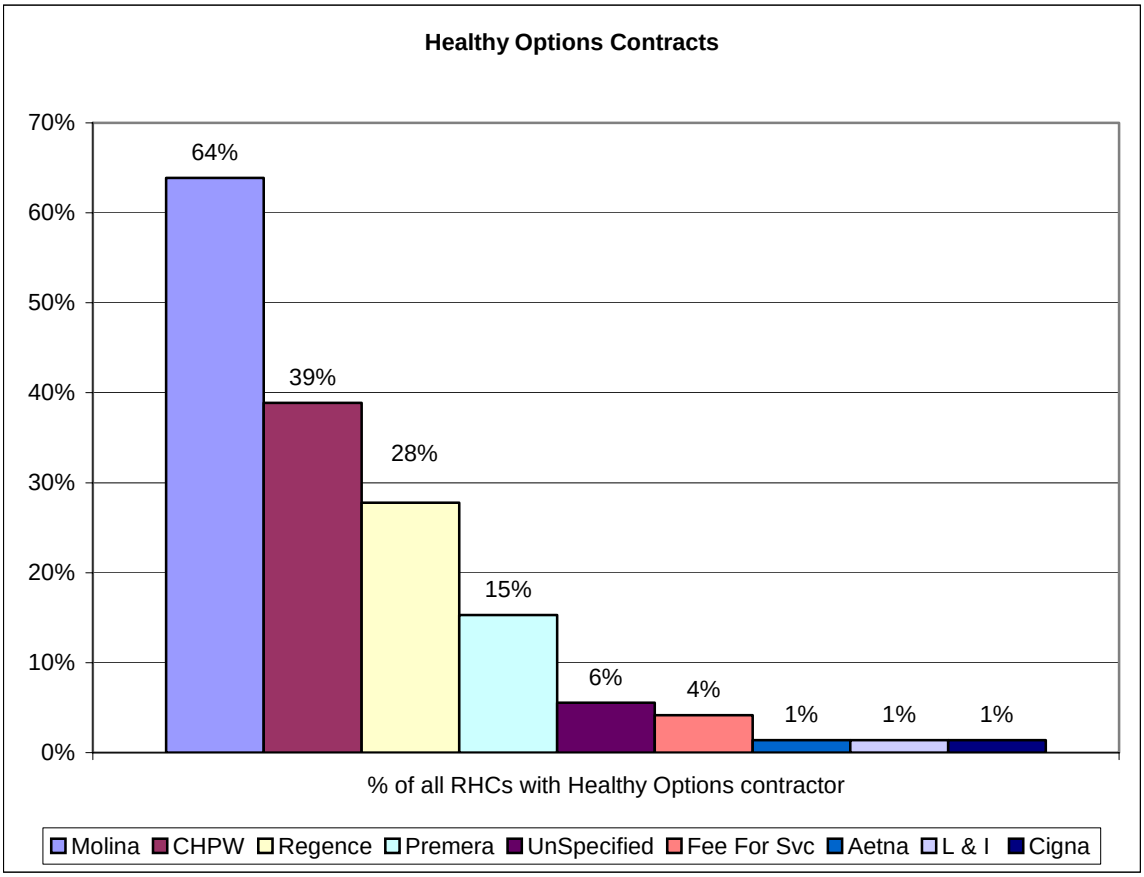
Chart 7.1 Commercial Health Plan Contracts



Molina has the greatest number of Healthy Options contracts (64%) with RHCs. CHPW, Regence, and Premera all have less than 40% of Healthy Options RHC contracts. CHPW* was more likely to contract with RHCs with two or fewer MD FTEs in isolated areas than with larger staffed clinics in large towns. Forty-three percent (43%) of RHCs have just one Healthy Options contract, 35% have two HO contracts, 10% have three, and 3% have four Healthy Options contracts. Four percent (4%) of RHCs have fee for service Healthy Options contracts. These contracts are in the small town and isolated areas, with RHCs having smaller MD FTE staffing (Chart 7.2).

* CHPW is owned by The Community Health Centers, and therefore tends to contract with RHCs in areas where there is not a CHC located.

Chart 7.2 Healthy Options Contracts

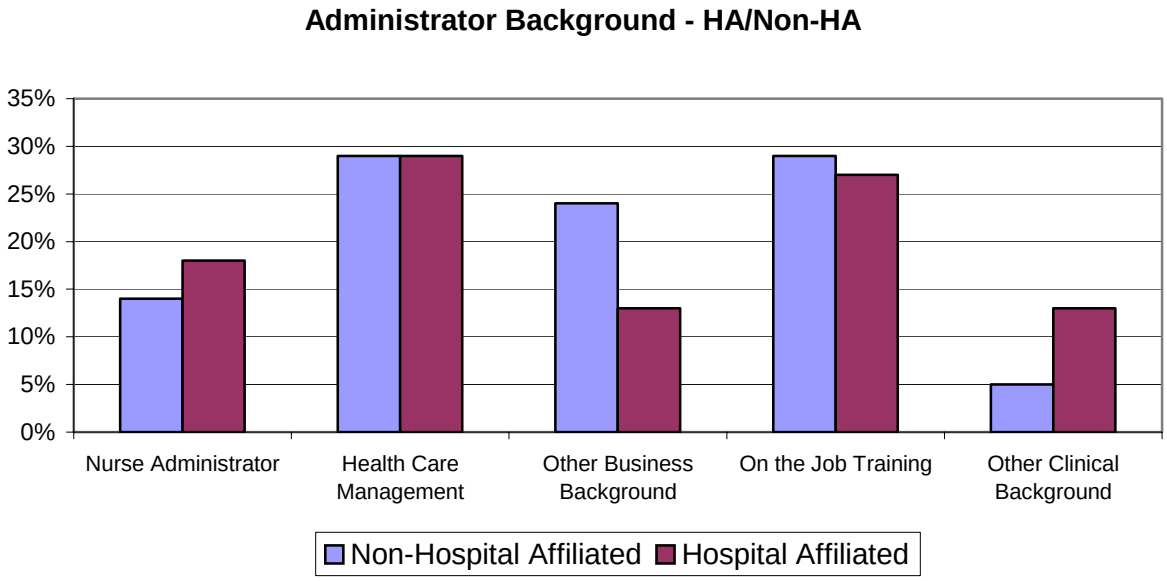


Organization and Management

Characteristics of Administrators

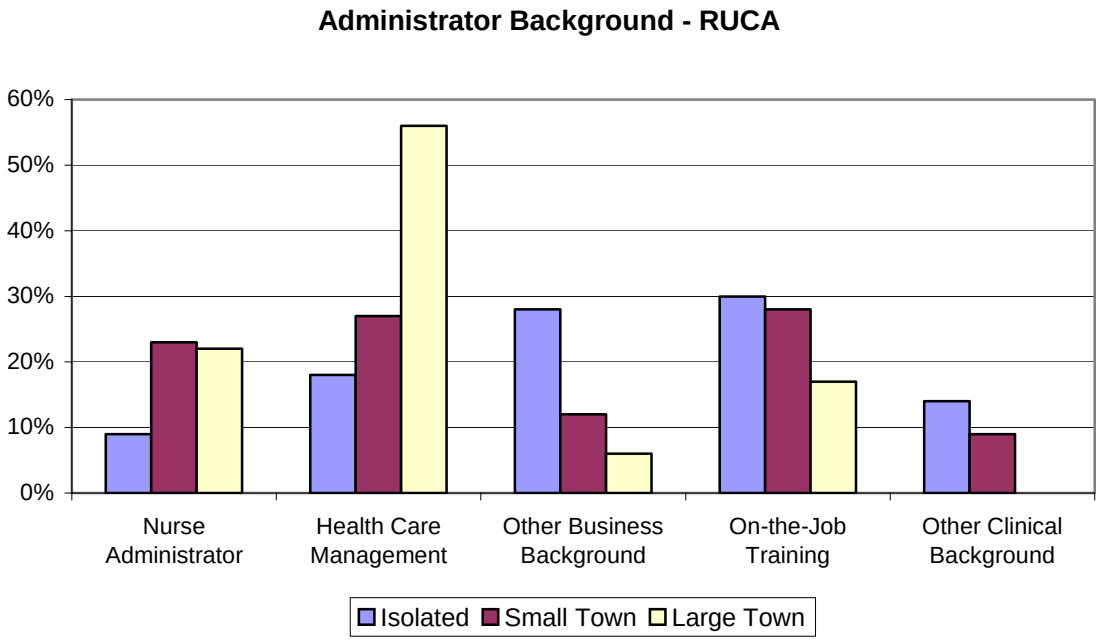
Background and preparation of Clinic Managers for their roles varied from Master's- level education to "on-the-job" training.

Chart 8.1 Administrator Background – Hospital-Affiliated and Non-Hospital-Affiliated



As shown in Chart 8.2, the larger the community, the more likely it was to find administrators with healthcare management backgrounds.

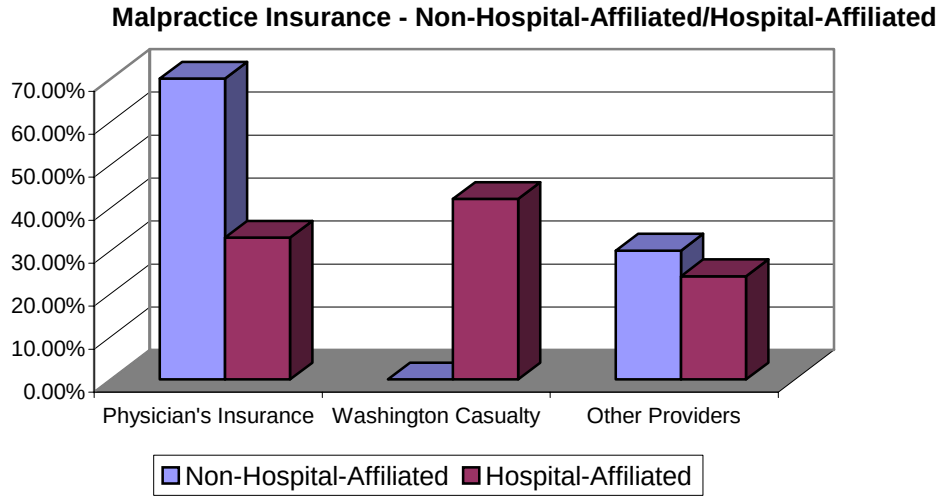
Chart 8.2 Administrator Background - RUCA



Liability Coverage

The largest portion of liability insurance coverage for the clinics is provided by two Washington-based companies, Physician's Insurance Company and Washington Casualty Company. Washington Casualty Company was created through hospitals in the state and it has the largest share of coverage for Hospital-Affiliated clinics. Physician's Insurance Company was started through the Washington State Medical Association and has the majority of coverage for Non-Hospital-Affiliated clinics as well as those in the larger communities (Chart 8.3).

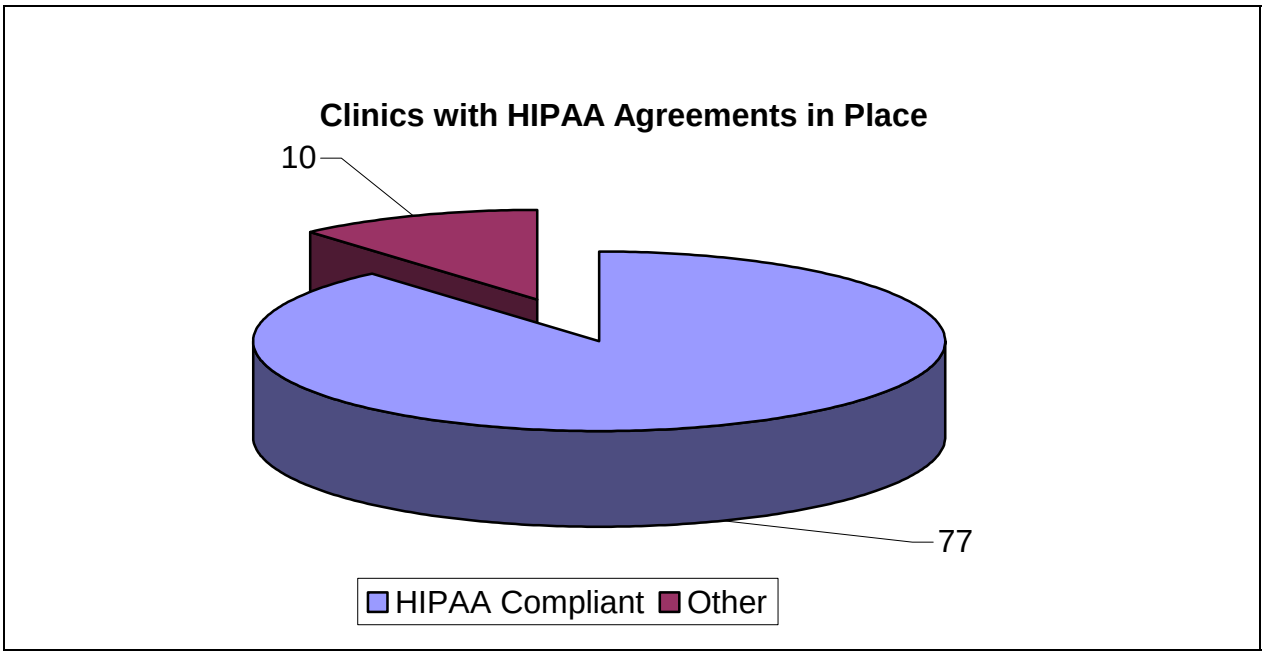
Chart 8.3 Malpractice Insurance – Non-Hospital-Affiliated / Hospital-Affiliated



HIPAA Agreements

Seventy-seven of the 87 clinics who responded to a query about whether they had HIPAA agreements in place with their contractors responded "yes." (This survey was done in the summer of 2003, before the deadline for compliance had been reached.)

Chart 8.4 Clinics with HIPAA Agreements in Place



Information Technology

Data management

All but three of the clinic administrators reported using computers in their daily work. All of the clinics reported some level of computerization.

Connectivity to other regional systems

Fifty-one (51) clinics indicated their computers were linked with other healthcare information systems. By far, most clinics (38) are linked to some version of the Meditech system, the majority through Inland Northwest Health Services (versions included Pointshare, Techtime, and Veripoint). Two clinics utilized Dairy Land (one through the hospital system), two listed Point Share and Prism. Millbrook, CareNotes, Emedsys and Lake Superior Software each had one clinic user.

Access to the Internet

Administration

Table 9.1 Internet Access - Administration

N=70	41	29	15	22	33	36	26	7	21	49
	HA	Non-HA	Large Town	Small Town	Isolated	2< MDs	2.1-5 MDs	>5 MDs	RHC 2 or< Yrs	RHC 3 or> Yrs
Computer	41	26	14	21	32	33	27	7	20	47
Internet Usage										
Drug Info	25	14	10	12	18	22	10	4	11	29
Patient Info	24	12	9	11	21	26	15	3	11	30
Specific Disease	28	18	10	16	19	23	15	4	12	34
Library Searches	25	13	9	15	14	18	15	5	11	28
Other*	26	16	9	14	20	17	21	5	10	33

*Other: professional education; Point Share; credentialing, insurance eligibility, National Rural Health Clinic Association, email, EMS, purchasing, legislative activity RCW searches, equipment comparisons, news services, business purposes, telephone numbers, directions for patients, DOH web-site, banking, referrals, CDC forms, Child Find, MGMA web-site, DSHS, government reports, research grant opportunities, and HIPAA information.

Providers

Seventy-five percent (75%) of RHC providers interviewed reported that they used computers that were connected to the internet. The largest usage was for email. When asked about their usage of Personal Data Assistants (PDAs), 53% of the providers stated they used one. Providers either were highly enthusiastic about using PDAs, or did not have nor want one.

Table 9.2 Internet Access - Providers

N=112	67	45	24	33	55	57	42	13	36	76
	HA	Non-HA	Large Town	Small Town	Isolated	2< MDs	2.1-5 MDs	>5 MDs	RHC 2 or< Yrs	RHC 3 or> Yrs
PDA	37	22	6	20	33	29	24	6	22	37
E-mail	56	35	20	26	45	45	37	9	62	29
Internet Usage										
Drug Info	45	29	12	26	36	38	26	10	48	26
Patient Info	42	23	11	18	39	38	23	10	48	17
Specific Disease	51	33	18	27	39	42	31	11	30	54
Library Searches	36	23	11	22	26	29	22	8	20	39
Other*	19	6	4	7	14	15	8	2	5	20

*Other: Resources; update subscriptions; diet programs; professional associations; NN/LM; ACP; uptodate.com; PubMed; DSHS; insurance info; herbal & supplement information; communication with other professionals; clinical consults; update journals; lab work; online pharmaceutical; supplies; EMS Medical Director correspondence; CME; subscribe to Hippocrates; read newspapers; news releases re healthcare; professional society bulletin; research and order equipment; track international medical sites (Australia); post grad students in ER to maintain Australian certification; patient hand-outs; treatment guidelines; and real estate listings.

Usage of Electronic Medical Records and Electronic Billing

Electronic Medical Records

While electronic medical records are not being utilized at very many of the Rural Health Clinics (13 of 69), almost every clinic manager commented that they were “thinking about it,” “researching it,” or planning to move to EMR.

Practice Management Software

Thirteen clinics reported having no practice software or looking into possibly purchasing software in the future. Eight clinics are using Lake Superior Software (LSS), many through Meditech. Five clinics reported using TechTime, five Medical Manager, four Smart Practice, four Vitalworks Prism, three Medware, and two each reported using Millbrook, MisysPM, Lytec, NextGen EPM, or CPSI. One clinic

reported using QuickBooks 2003. Others mentioned by single clinics were MM Systems Silverdale, Physician Office Manager by McKesson, Practice Partner, QSI, RPMS Pharmacy, Chart Care, Compumedic, Dairyland, ECS, Electronic Scheduler, Emedys, HBOC Practices Plus, Healthwind Horizon, Horizon, IDX, Ingenix, Medicell, Medisoft, and Medisoft Windows.

Fifty-four of the 69 reporting RHCs had some form of Practice Management Software, but 43% seemed to feel what they had was not adequate. The largest complaint was a lack of a scheduler program. Many commented that they were using the hospital system and that it didn't work very well for clinics.

Table 9.3 Usage of Electronic Medical Records and Electronic Billing

N=69	41	28	16	20	33	35	27	7	20	49
	HA	Non-HA	Large town	Small town	Isolated	2<MDs	2.1-5 MDs	>5 MDs	RHC 2 or < yrs	RHC 3 or > yrs
EMR	7	6	4	1	8	7	4	2	4	9
Electronic Billing	40	20	15	16	29	30	24	6	17	43
Practice Software	28	26	15	18	21	29	18	7	13	41
PS Adequate	13	18	11	8	12	16	9	6	6	25

Billing and Coding Assistance

The clinics varied widely about where they went to get billing and coding assistance.

Listed by the Non-Hospital-Affiliated clinics as sources of assistance:

- Certified coders employed – 3
- Insurance companies – 3
- CMS – 2
- Medical Manager – 2
- Other RHCs – 2
- Billing company's reference book – 2

Others mentioned by only one clinic were: Wenatchee Valley Clinic, accountant's office, seminars, bulletins, DSHS, CPT Code Book, St. Peters, and Pediatric Coding Alert. One clinic reported that they outsourced this function.

The Hospital-Affiliated clinics predominantly reported using their affiliated hospital billing office as their first line of assistance. They also mentioned using other RHCs, insurance companies, MAA, Medicare and outside consultants.

RHC Role to Increase Access to Primary Care

Medicare, Medicaid and the Uninsured

Survey results show that RHCs significantly increase access for Medicare and Medicaid recipients, as well as for the uninsured population. Stabilization of medical practices occurs because the enhanced reimbursement received through RHC certification increases primary care access for these populations. Due to the preferred reimbursement received from these payers, 98% of RHCs are accepting new Medicare patients and 99% are accepting new Medicaid patients. Of the small percent not accepting new Medicare or Medicaid, the variation occurred with large town, Non-Hospital-Affiliated clinics with over 5 FTE doctors in the clinic.

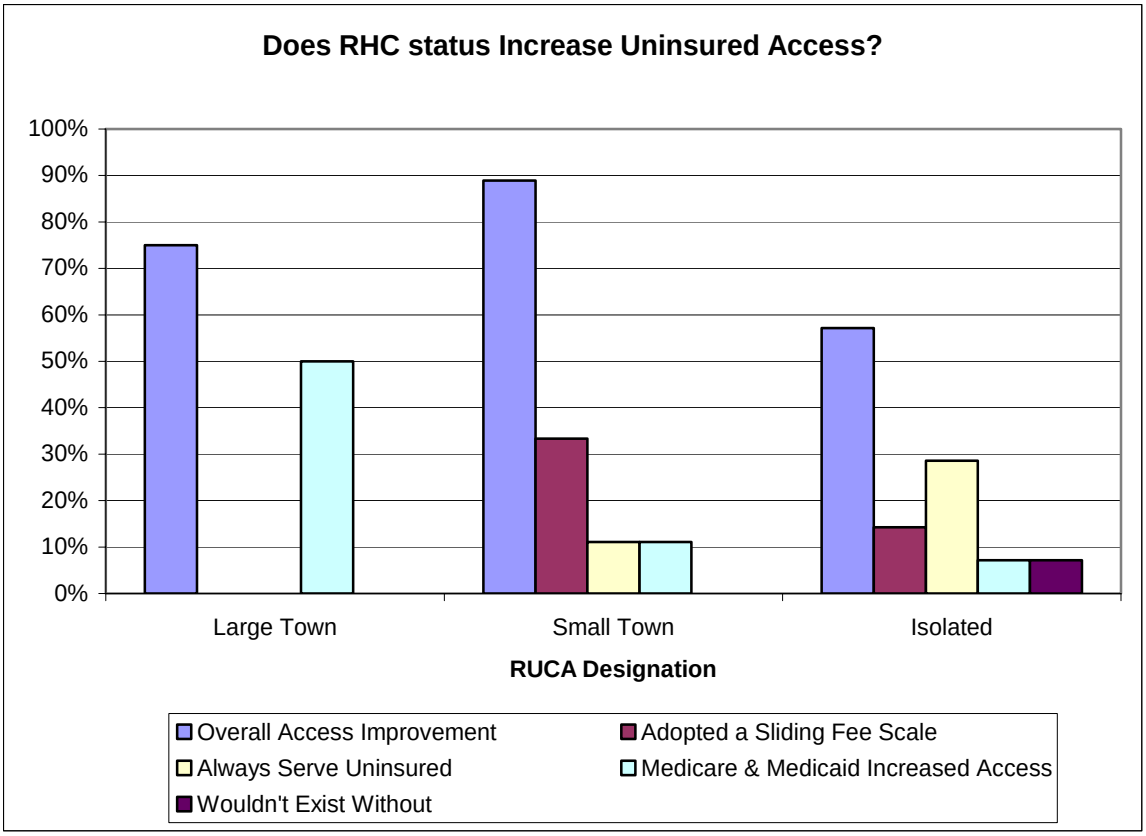
The primary reason provided for not accepting new Medicare or Medicaid was a full practice. Those clinics indicated that they were in the process of recruiting an additional mid-level or doctor to be able to expand and accept new patients. Some clinics also indicated that they had no ability to expand their practice due to physical space limitations at the clinic site. Only 5% (N = 4) of the RHCs have discontinued seeing patients in other payer categories, and that was the Basic Health Plan. These RHCs were in isolated areas, not affiliated with a hospital, and had 2 or fewer physician FTEs.

From the clinic administrator's perspective, RHC status has improved access for the uninsured (Chart 10.1).[5] Non-Hospital-Affiliated clinics in isolated communities responded that without RHC status their clinic would not exist for anyone in the community, while clinics in small and large towns indicated that, overall, the program makes it easier to adopt a sliding fee scale policy. Clinics in all categories except for large town stated that they had always

[5] Narrative responses were coded for analysis by identifying key words and phrases. Though Medicare and Medicaid are not the uninsured, this response occurred often enough to include in the results and is considered an indicator of increased access. This is particularly true as states cut Medicaid benefits and populations move on and off Medicaid, thereby influencing the level of uninsured in a practice.

served the uninsured in some capacity and that the RHC program allowed them to provide greater access due to increased profit margins.

Chart 10.1 Does RHC Status Increase Uninsured Access?



Sliding Scale Fees

Fifty-five percent (55%) (N=87) of RHCs have a sliding fee scale for their clients. Of these, 43% were Non-Hospital-Affiliated and 67% were Hospital-Affiliated clinics. The more FTE MDs on clinic staff, the more likely it was to have a sliding fee scale, with 71% of clinics staffed by more than 5 MD FTEs indicating they have a sliding fee scale policy.

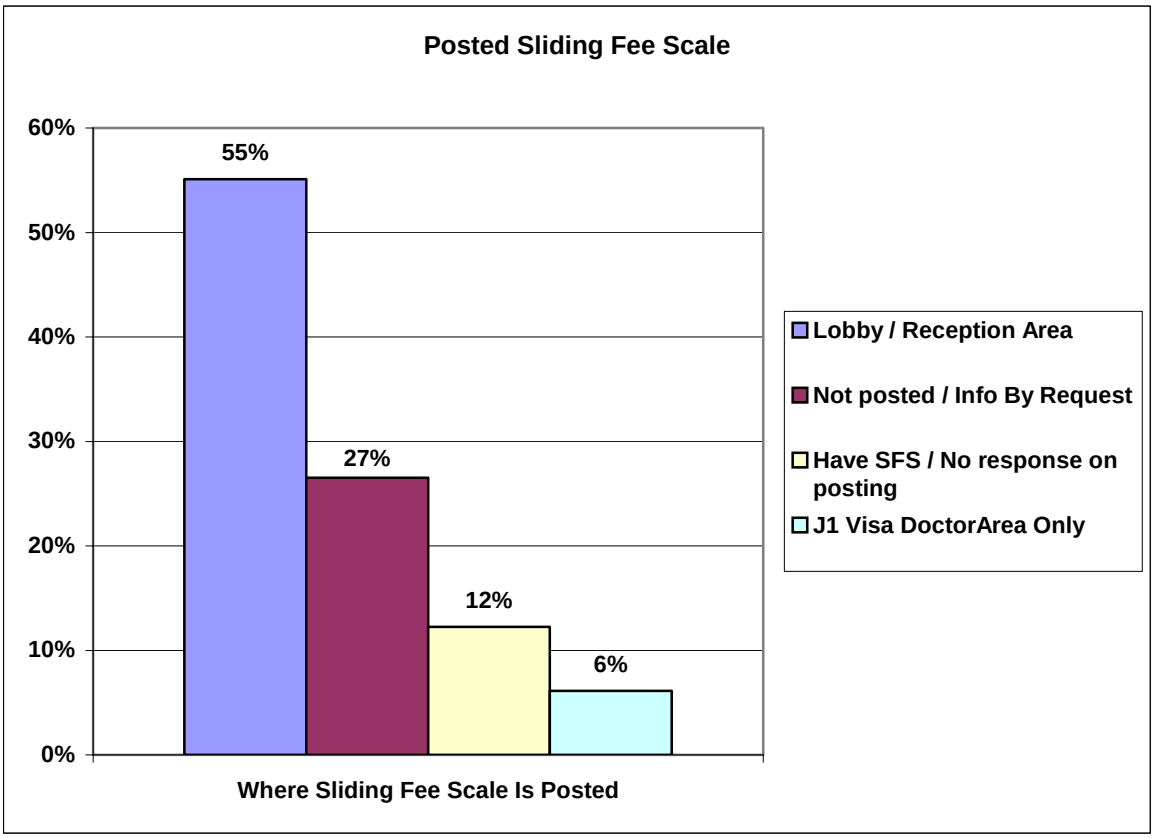
The smaller and more isolated a clinic, the less likely they were to have a formal sliding fee scale policy. Sixty-one percent (61%) and 63% respectively of large and small town areas have a sliding fee scale policy.[6] The majority of clinics have their sliding fee scale posted in the lobby / reception area.

[6] For an open question about where the sliding fee scale was posted, responses were coded for analysis into common categories.

Large town, Non-Hospital-Affiliated clinics are the only RHCs that currently have J1 Visa doctors working in them. Their sliding fee scale policies are posted specifically in areas where J1 Visa doctors are working in compliance with requirements for the J1 Visa program.

Those RHCs that do not have it posted, have a sliding fee scale available upon request or offer it through their billing and business office for uninsured patients.

Chart 10.2 Posted Sliding Fee Scale



Clinic Stability

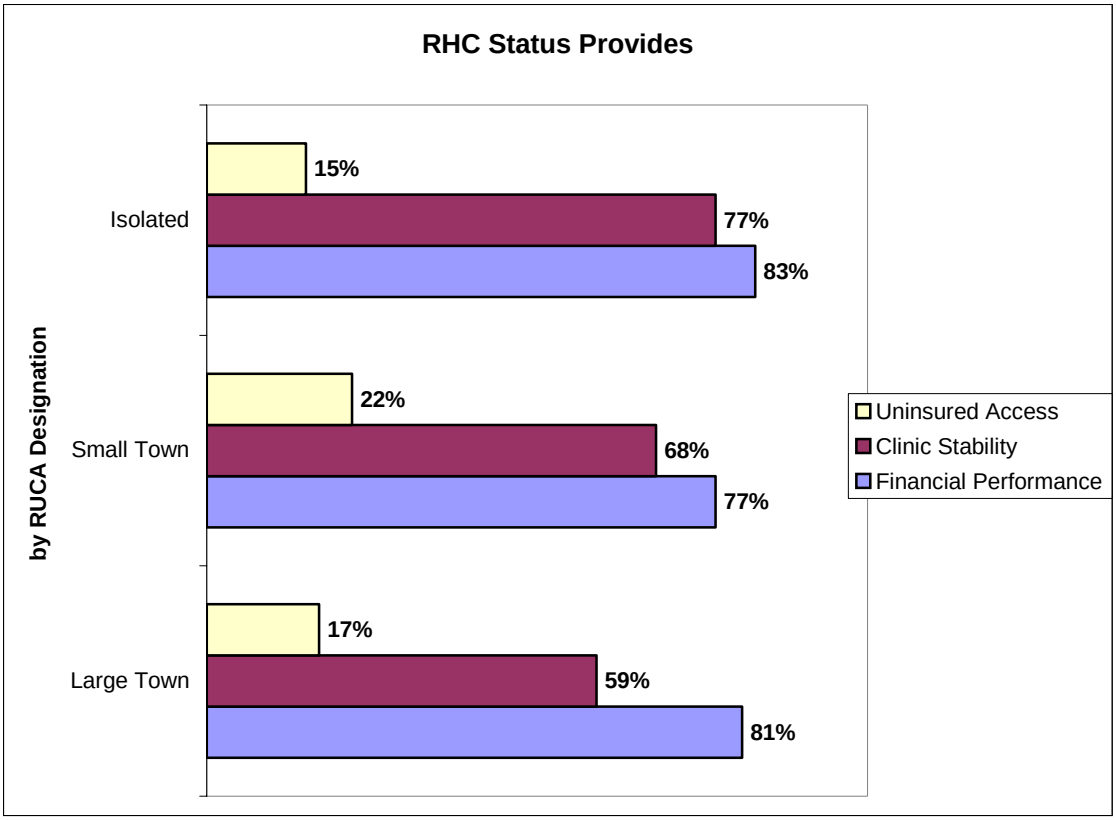
Indicators of the stability of healthcare access in a community were measured through a series of Likert scale questions[7]. These questions determined if Rural Health Clinic certification had influenced the overall stability of the clinic, the financial performance of the clinic and uninsured access (Chart 10.3).[8] Though clinics across all variables reported significant improvement with clinic stability and financial performance, Non-Hospital-Affiliated clinics in isolated areas responded with the highest percentages

[7] All Likert scales were converted to scales of five to standardize reporting. Five represents the greatest change.

[8] The Likert scale responses ranged from 0 = significantly reduced, 3 = no change, 5 = significantly improved. The percentages reflect those responses of a 4 or a 5 that indicate improvement.

regarding RHC certification creating clinic stability. Seventy-seven to eighty-six percent (77-86%) across all categories reflect significantly improved financial performance; Non-Hospital-Affiliated clinics with five or more MD FTEs reported the highest percent gain (25%) for greater uninsured access because of RHC status.

Chart 10.3 RHC Status Provides



Two other services were identified as contributing to increased access to health services in a rural community. These services are pharmacy and interpreter access.

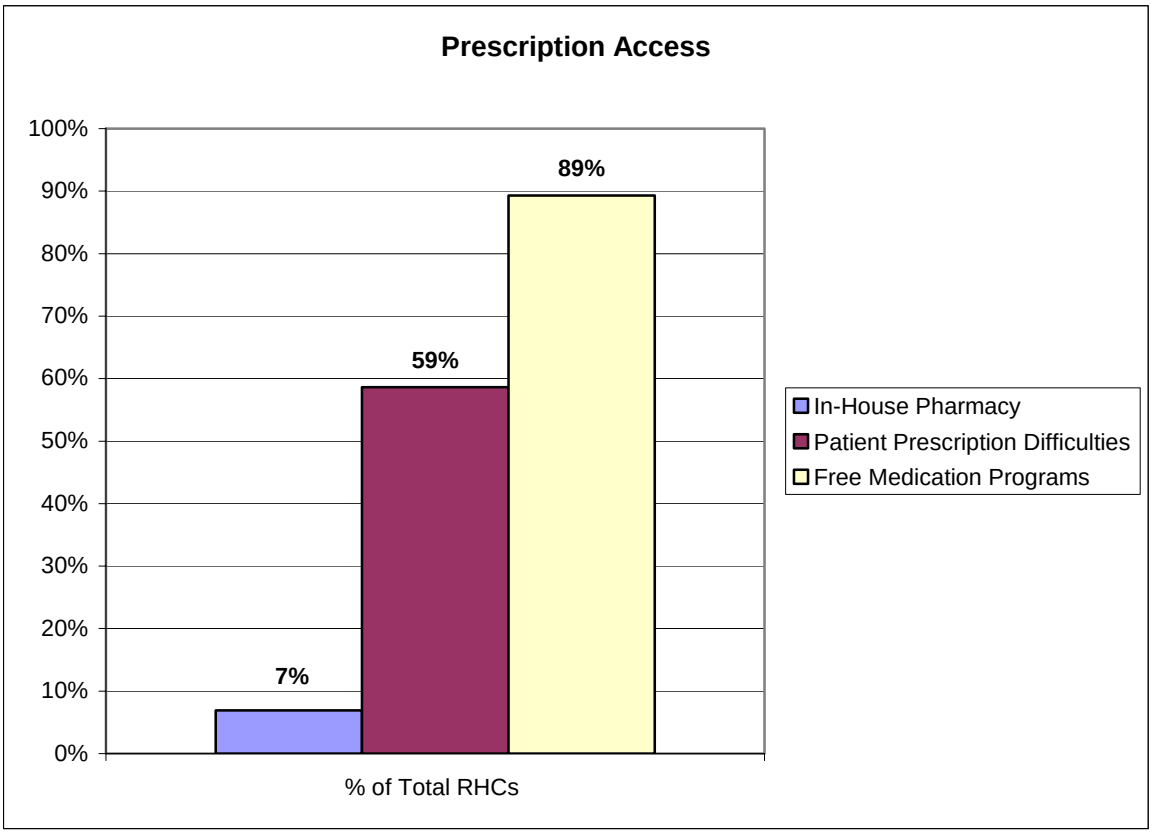
Pharmacy

With the prevalence of pharmaceutical needs in our health delivery system, the accessibility of pharmacy services in rural communities was evaluated through a series of questions (Chart 10.4). Seven percent (7%) of RHCs indicated that they have an in-house pharmacy. These 7% were Non-Hospital-Affiliated RHCs, had greater than 5 MD FTEs and fell across the spectrum of geographic areas. Fifty-nine percent (59%) of all responses indicated that their patients had communicated difficulties in getting their prescriptions, including both access and cost considerations. Little variation was seen across geographic areas, with 56% of small towns indicating difficulty, while 60% of isolated areas and 61% of large towns

expressed difficulty. Greater variation exists between clinic size, with 66% of fewer than 2 FTE MDs having patients express pharmacy issues, 48% greater than 3 – 5 MD FTEs, and 43% greater than 5 MD FTEs having patients express issues with pharmacy access.

Eighty-nine percent (89%) of all clinics indicated that they use free medication programs for their patients though few could quantify the dollar amount by which their patients benefited from these programs. Free pharmaceutical samples were included in the category of free medication programs indicating that this was a major source of pharmaceuticals for their clients. Specifically, 83% of large towns, 92% of small towns, and 90% of isolated areas use free medication programs.

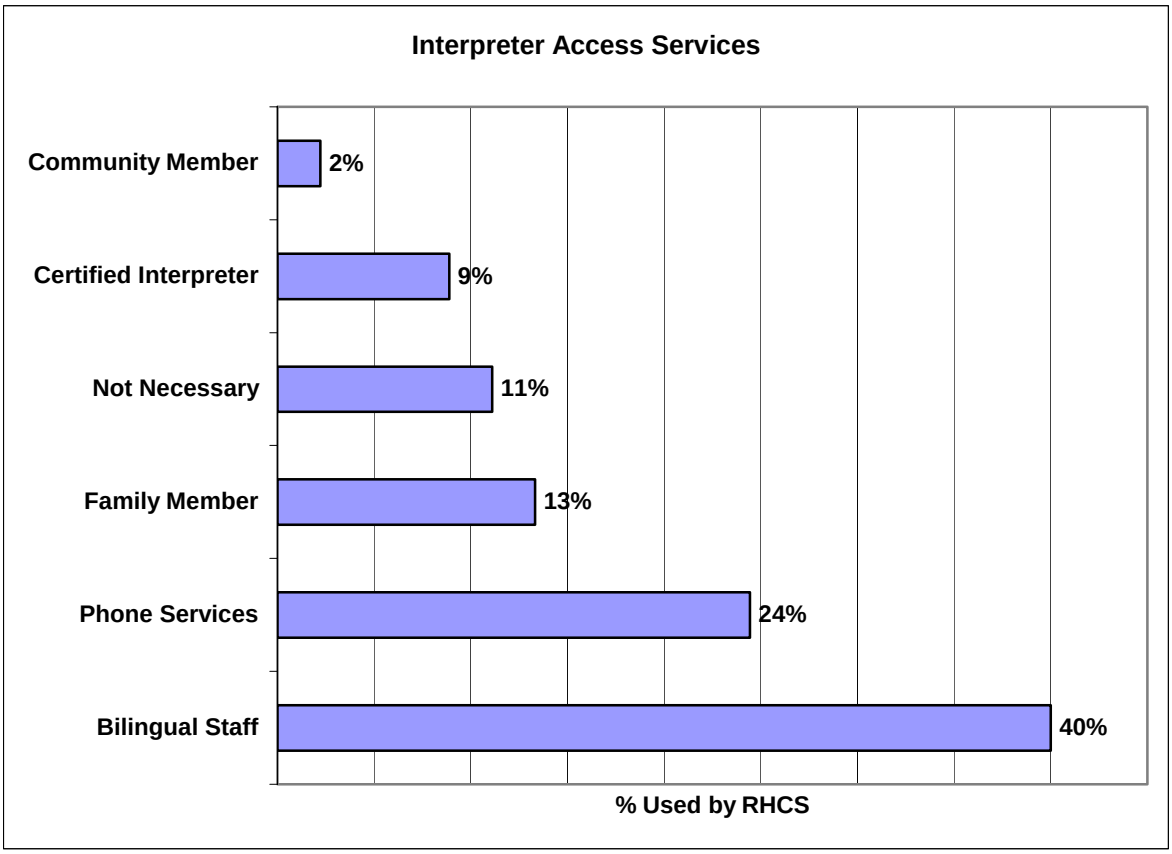
Chart 10.4 Prescription Access



Interpreter Access

With the increasing diversity of minority populations in rural Washington, access to interpreter services is seen as a characteristic of the safety net (Chart 10.5). Eight-five percent (85%) of respondents indicated that they have access to certified interpreters. Ninety-four percent (94%) of large town areas use Certified Interpreters, with 83% of both small town and isolated areas indicating they had access to Certified Interpreters but also used different methods for interpretation. Actual use of interpreter services yielded a broad set of responses. Forty-nine percent (49%) indicated that they had bilingual staff to address the need for interpreter services. The most common language for which RHCs used interpreters was Spanish, with Russian being the second primary language. The Hispanic population is the largest growing minority population in the state, though it is recognized that there are growing eastern European/Russian communities. Unlike the integration of Hispanic communities throughout the state, the Eastern European populations are clustered in the large town areas.

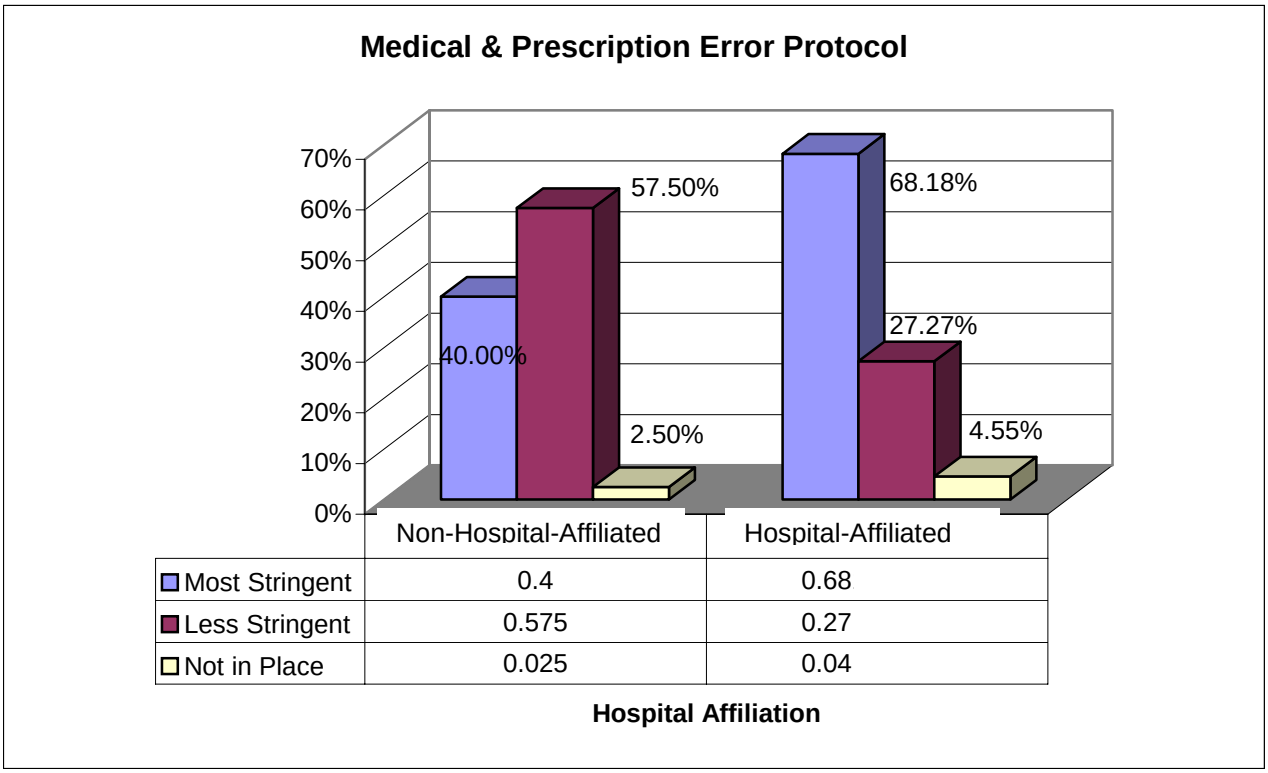
Chart 10.5 Interpreter Access Services



Quality Improvement Characteristics

Clinics responded to specific questions about whether they had a patient satisfaction survey, a process for immunization updates, and a state certified quality improvement plan, and how they handle medical and drug errors[9] as indicators of quality processes. Hospital-Affiliated clinics responded with more stringent protocols for identifying, correcting, and reporting medical and drug errors than Non-Hospital-Affiliated clinics.

Chart 11.1 Medical and Prescription Error Protocol



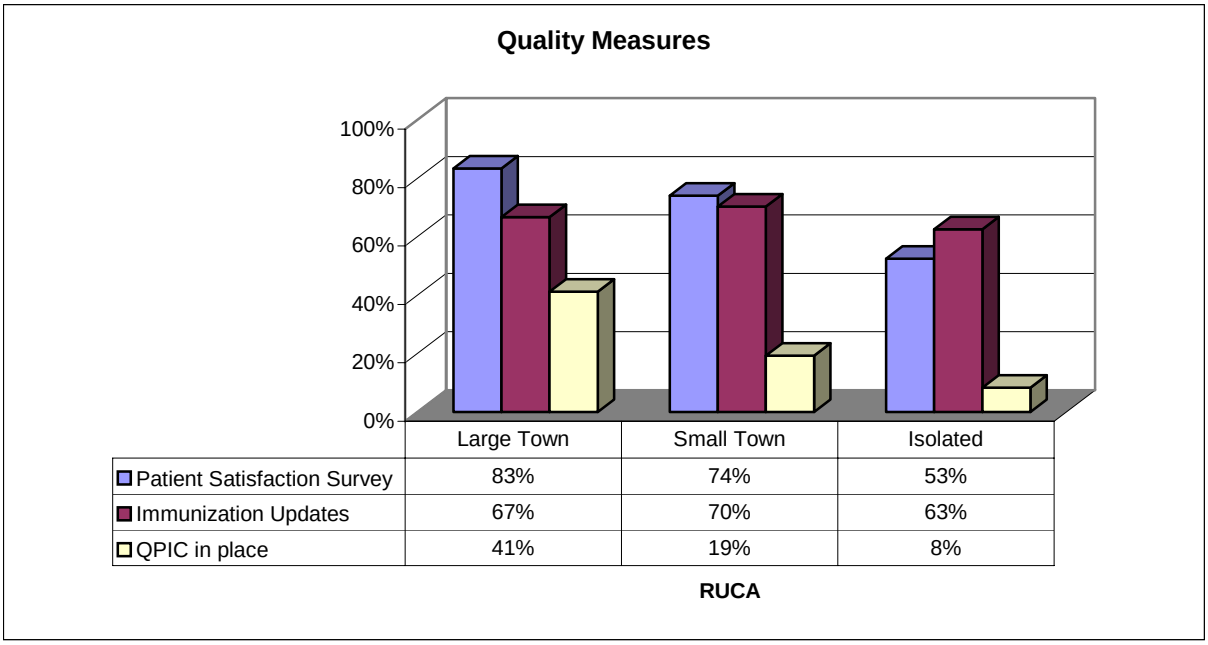
A patient satisfaction survey was the most widely used quality assessment tool, with immunization updates also widely utilized. The larger clinics located in large town areas were more likely to have a state-certified quality plan.

There has been much discussion about how to implement, measure, and report quality improvement in Rural Health Clinics. Legislation has been passed and rules have been introduced by Centers for

[9] This was a narrative response question. Responses were coded for analyses and categorized by most stringent, less stringent, and no protocol. Most stringent responses referred to a process or plan; less stringent responses indicated they had components in place.

Medicaid and Medicare Systems (CMS) (and since withdrawn) defining a Quality Assessment and Performance Indicators (QAPI) program. RHCs in Washington have a range of formal and informal methods to measure quality in their clinics. Many clinics have defined procedures for considering new ideas and suggestions, where others have policies that are more informal. Standards for identifying, measuring and reporting appropriate quality programs could benefit RHCs on a continuing education basis.

Chart 11.2 Quality Measures



	Large Town	Small Town	Isolated
Patient Satisfaction Survey	83%	74%	53%
Immunization Updates	67%	70%	63%
QPIC in place	41%	19%	8%

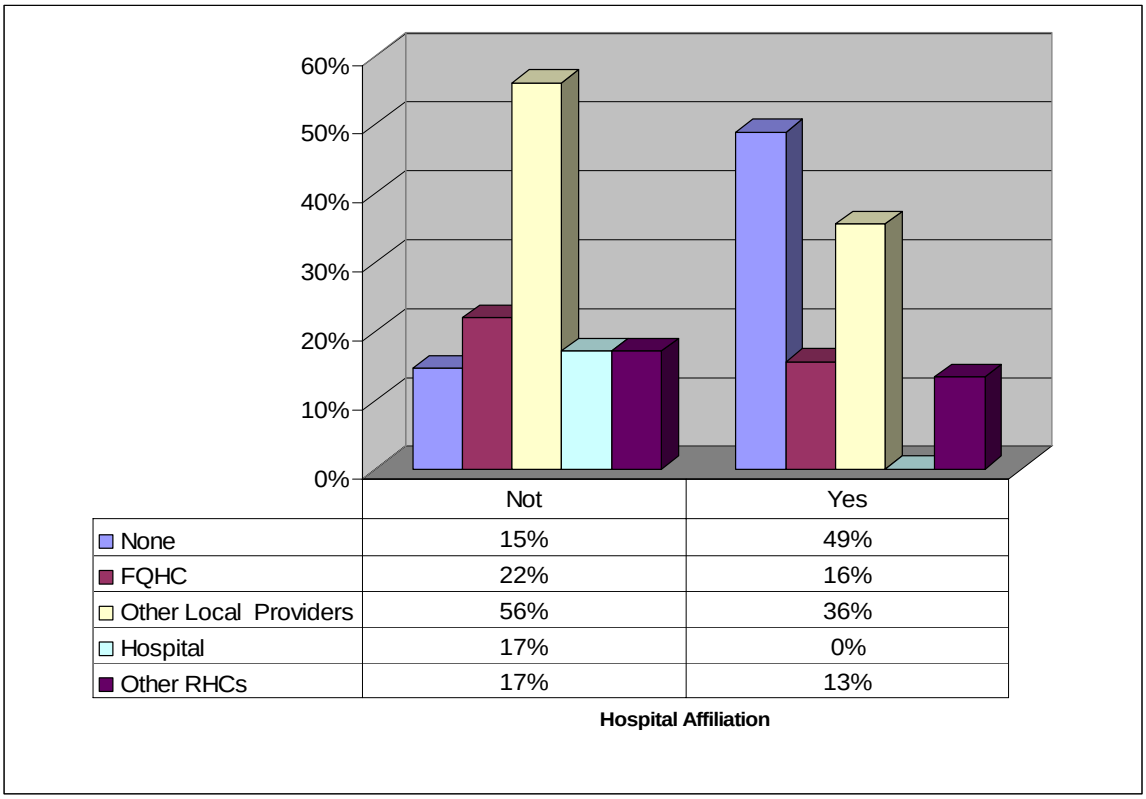
Credentialing is a process required by health plans to assure that the healthcare provider has received the appropriate education, training and professional licensure. Larger clinics process their own provider credentials, whereas clinics affiliated with hospitals have the hospital do the credentialing. Non-Hospital-Affiliated clinics in isolated areas indicated that they have the insurance plan do the credentialing.

Clinic Competition and Relationships

Clinics were asked whether they had competition and with whom.

The Hospital-Affiliated RHCs were more likely to respond they had no competition (49%) than Non-Hospital-Affiliated (15%) which bears out the analysis that many of the HA RHCs have become part of the Public Hospital District as a means of survival.

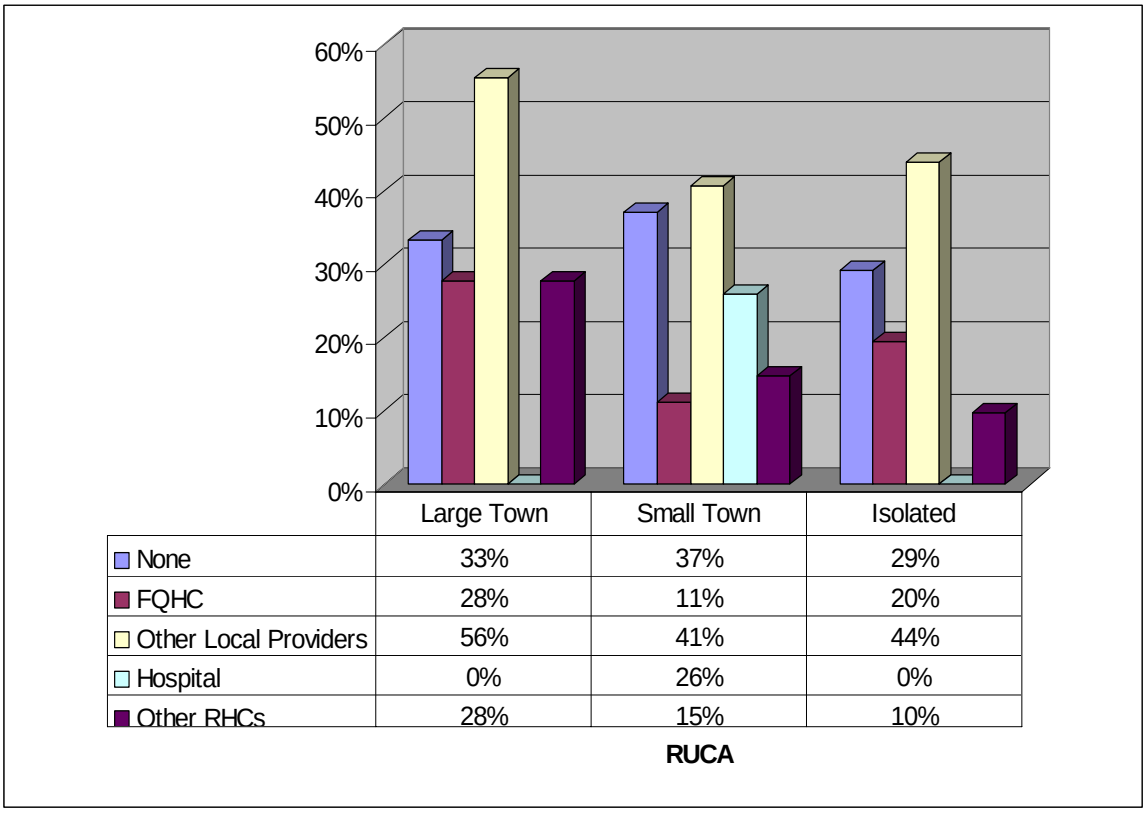
Chart 12.1 Competitors – Hospital-Affiliated and Non-Hospital-Affiliated RHCs



	Not	Yes
None	15%	49%
FQHC	22%	16%
Other Local Providers	56%	36%
Hospital	17%	0%
Other RHCs	17%	13%

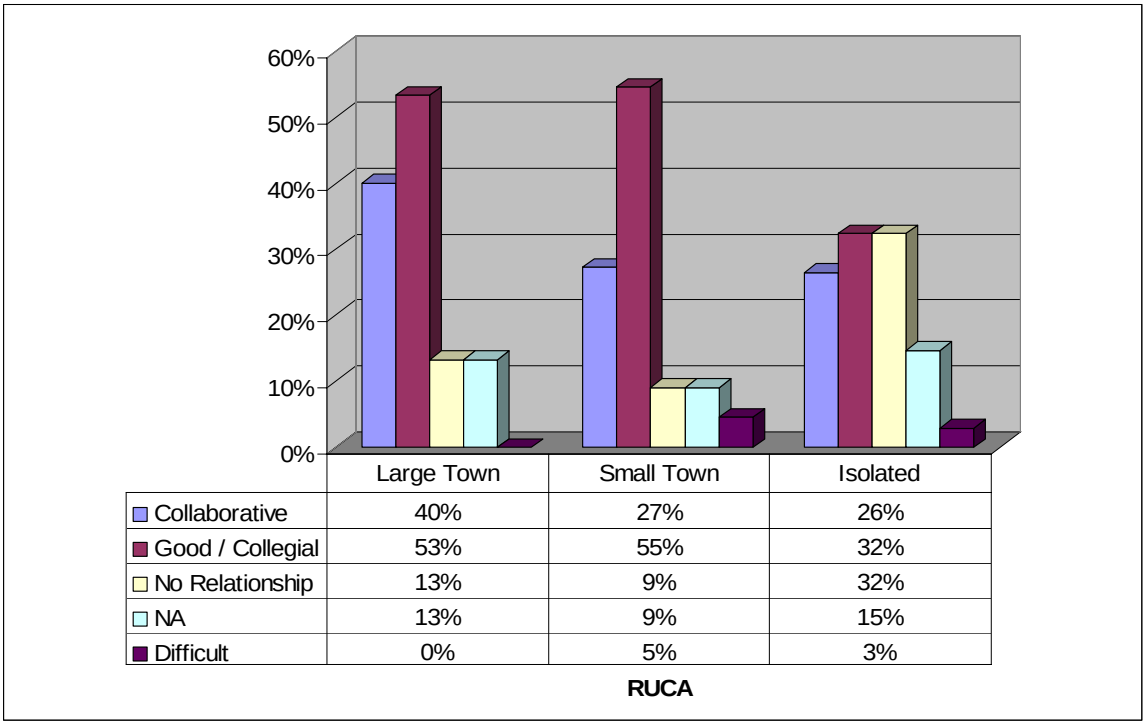
Just about a third of the RHCs in all sizes of communities (RUCA) also stated that they had no competition. For all of the RHCs, "other local providers" was listed most frequently as their competition.

Chart 12.2 Competitors – Isolated, Small Town and Large Town



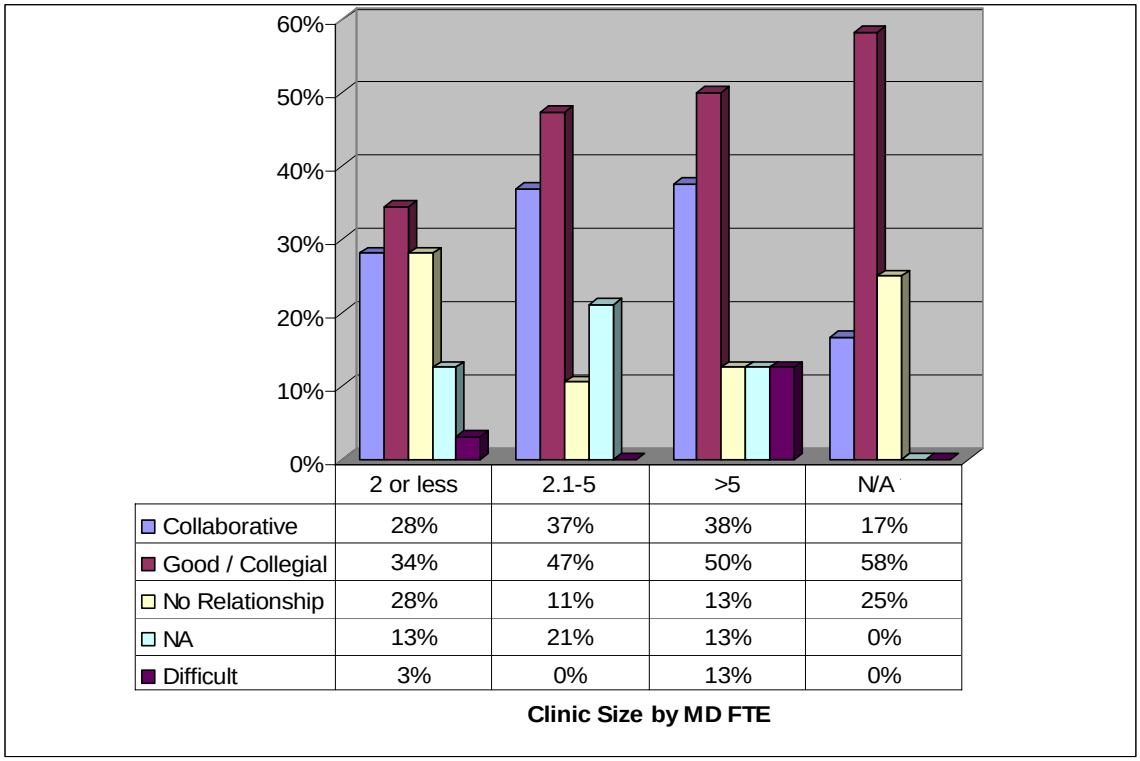
When asked about relationship with their competitors, most of the RHCs in all sizes of communities responded that their relationships were either Good/Collegial or Collaborative.

Chart 12.3 Relationships with Competitors – Isolated, Small Town and Large Town



In the larger clinics (five physicians or more) 13 percent of the RHCs did report that their relationship with competitors was "difficult," while only 3 percent of the clinics with two or less providers stated that the relationship was difficult.

Chart 12.4 Relationships with Competitors – By Number of Physicians



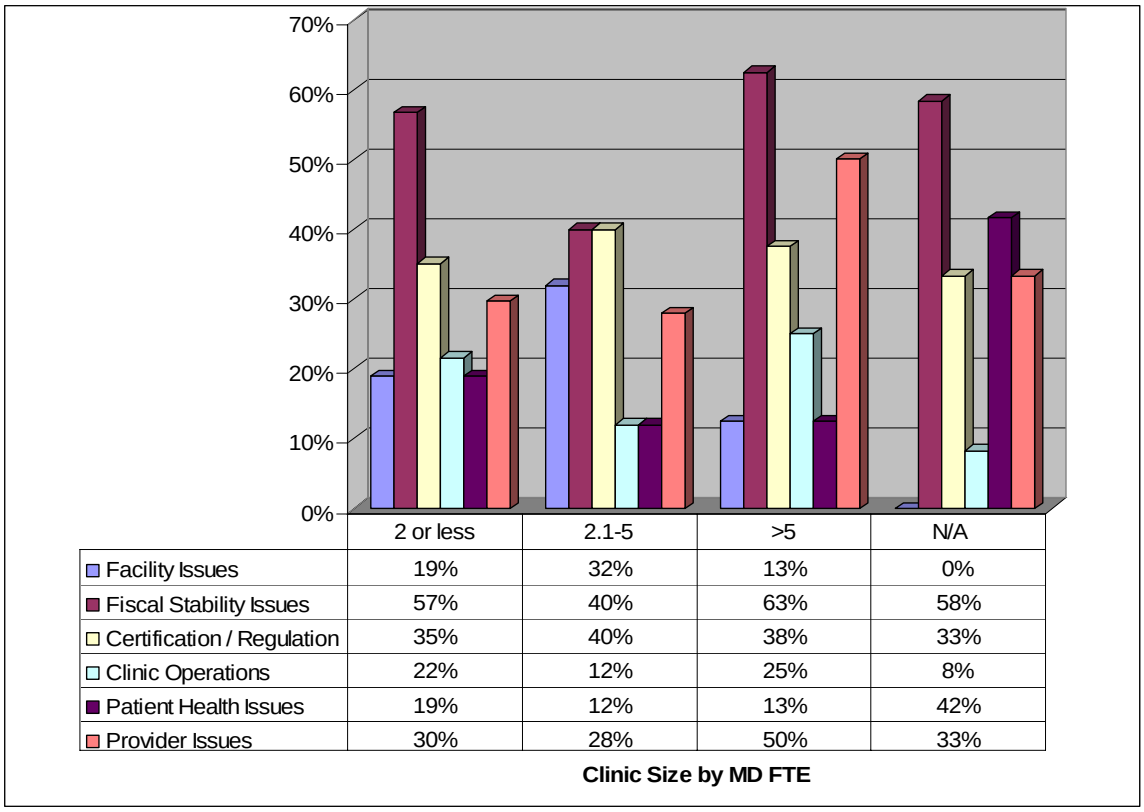
	2 or less	2.1-5	>5	N/A
Collaborative	28%	37%	38%	17%
Good / Collegial	34%	47%	50%	58%
No Relationship	28%	11%	13%	25%
NA	13%	21%	13%	0%
Difficult	3%	0%	13%	0%

Clinic Size by MD FTE

Challenges for Rural Health Clinics

The clinics were asked an open ended question as to what they saw as their greatest challenges. Regardless of size, fiscal stability remains at the top of the list of challenges.

Chart 12.5 Clinic Perceptions of Challenges – By Number of Physicians

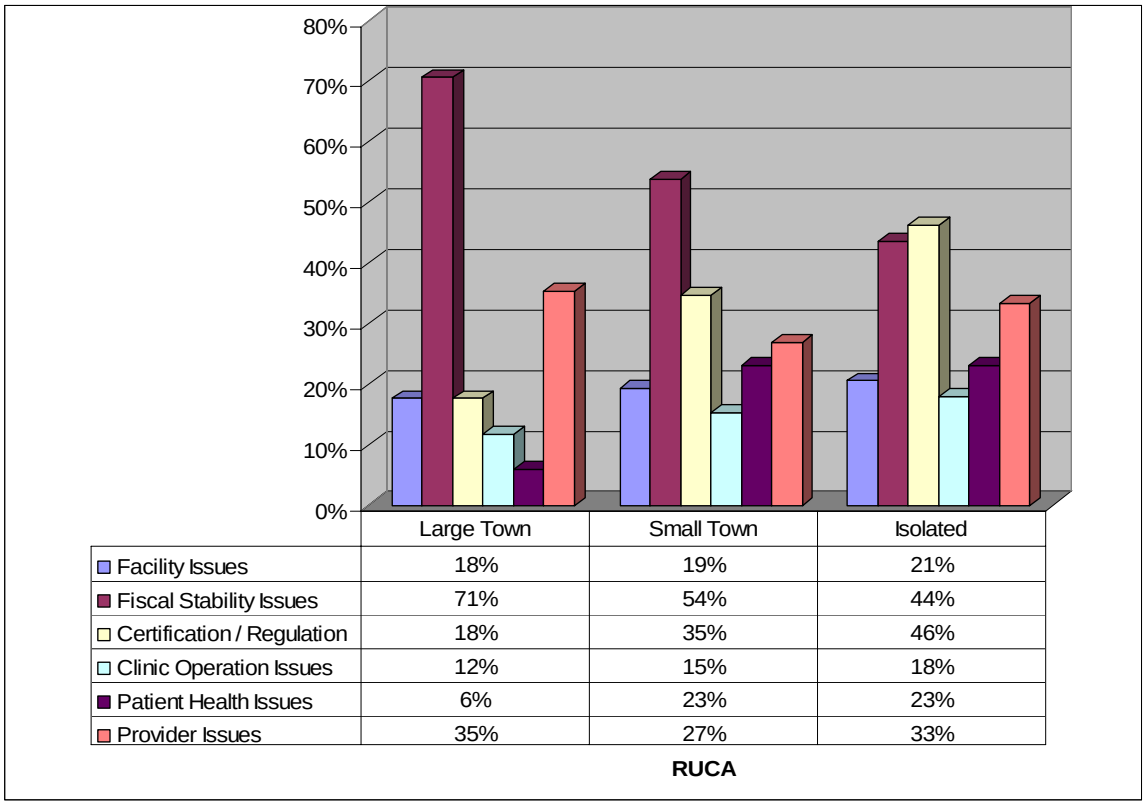


	2 or less	2.1-5	>5	N/A
Facility Issues	19%	32%	13%	0%
Fiscal Stability Issues	57%	40%	63%	58%
Certification / Regulation	35%	40%	38%	33%
Clinic Operations	22%	12%	25%	8%
Patient Health Issues	19%	12%	13%	42%
Provider Issues	30%	28%	50%	33%

Clinic Size by MD FTE

For smaller communities, however, certification and regulation issues ranked high and had the highest ranking in isolated communities. For all of the clinics, provider issues ranked third on their lists. Other issues mentioned were Facility Issues, Clinic Operations and Patient Health Issues.

Chart 12.6 Clinic Perceptions of Challenges – Isolated, Small Town and Large Town



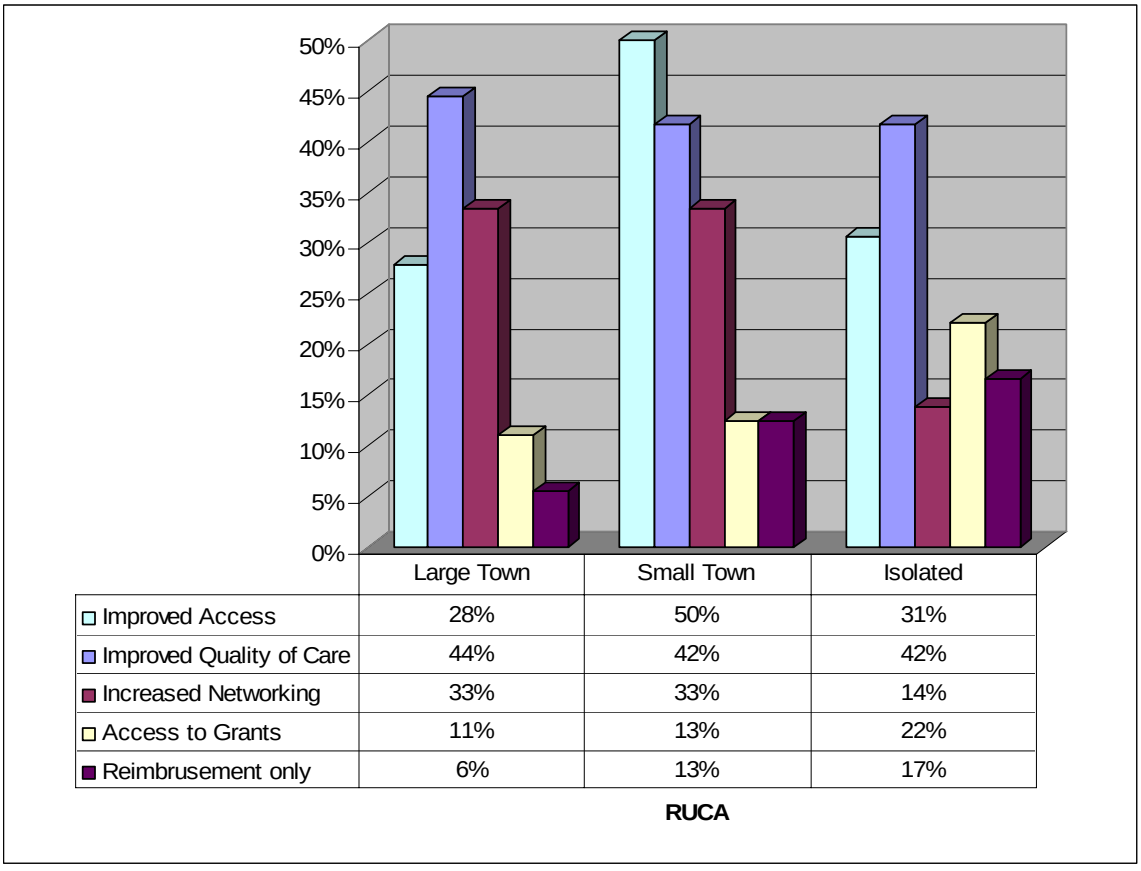
	Large Town	Small Town	Isolated
Facility Issues	18%	19%	21%
Fiscal Stability Issues	71%	54%	44%
Certification / Regulation	18%	35%	46%
Clinic Operation Issues	12%	15%	18%
Patient Health Issues	6%	23%	23%
Provider Issues	35%	27%	33%

RUCA

Benefits of Being a Rural Health Clinic

The clinics were asked what the benefits of being certified as a Rural Health Clinic were besides the enhanced financial reimbursement. Improved access for Medicaid, Medicare and uninsured patients and improved quality of care were most often mentioned. Increased networking (described by one as being part of an association) was also mentioned. Twenty-two percent (22%) of the isolated communities cited access to grants as another benefit. And a few of the clinics (6-17 %) could only perceive financial benefits.

Chart 12.7 Clinic Perceptions of Benefits – Isolated, Small Town and Large Town



	Large Town	Small Town	Isolated
Improved Access	28%	50%	31%
Improved Quality of Care	44%	42%	42%
Increased Networking	33%	33%	14%
Access to Grants	11%	13%	22%
Reimbrusement only	6%	13%	17%

RUCA

Observations

Best Financial Performance Practices

Rural Health Clinics play an essential role in their communities and in the overall Washington state rural health system. These clinics provide access to care and, in particular, are a key part of the safety net for uninsured, Medicare and Medicaid patients. In many cases these clinics are the only available source of care.

For purposes of this project, "best practices" have been defined only in financial and operational terms. It is important to note that there are also quality of care, access, and patient satisfaction "best practices." We have not attempted to define these due to limitations in data. Ultimately, the real "best practices" are those which best mesh with the comprehensive needs of the communities where they operate for providing financial value, access for all, high quality care, and patient satisfaction.

Recognizing that this project's definition of "best practice" is limited, there is still value in identifying yardsticks for strong financial performance against which all RHCs can compare themselves. With these yardsticks, clinics can more readily make conscious choices about trading off clinic financial performance for overall system (including hospital) performance, improved access, or other goals.

East West Consulting used four measures to identify financial performance best practices. These were:

- Average or better productivity (visits/MD FTE)
- 60th percentile or better medical revenue/MD FTE)
- 60th percentile or better physician compensation (physician cost/MD FTE)
- Absence of a significant operating deficit

By applying these measures to the sample data, East West Consulting was able to identify seven clinics which meet each of the above four standards.

What Were the Common Characteristics of the Financial Best Performers?

- **Practices had higher than average revenue per visit**

  Most often this higher revenue/visit was driven by having a relatively broad mix of physician specialties and/or by having ancillary services within the clinic site. Specialties such as general surgery or neurology command higher revenues/patient and ancillaries provide an added revenue stream. Some communities, however, are not big enough to support consulting specialists and in these communities there may only be enough volume for a single lab or radiology service, often at the hospital.

- **Practices had below average overhead rates**

  In most cases, the financial best performers actually were more expensive to operate on a per MD FTE basis. However, greater volumes and increased revenue/visit more than overcome the higher cost structure. As a result, more revenues were left after paying support and non-personnel costs. The average overhead rate of the seven best practice clinics was 50% contrasting with 60% for the overall sample.

- **Clinics had superior AR performance**

  Best practice clinics had 75% of their AR at 60 days or less compared to 65% for the entire group of RHCs.

- **Clinics had higher proportions of Medicare patients**

  While the proportions of Medicaid patients didn't vary greatly between "best practice" clinics and all others, the better performing clinics had strikingly higher (35% of all visits) Medicare proportions than the overall sample (25%). It is not possible, with the available data, to determine whether more Medicare was a contributor to better performance or simply a by-product. It is striking that conventional wisdom among practices is to avoid high Medicare patient loads. All the best practice clinics were subject to the Medicare cost cap which was $64.78 in 2002.

Observations

- **Clinics all had at least two physicians in the practice**

  The median number of MDs among the best practices was 8.85 and the mean was 11.37. For the whole sample of RHCs, the median was 2.8. At the other end of the scale, the most financially stressed practices were often solo practices. The reasons for these are likely that it is difficult to achieve economies of scale in solo practice and, with cost caps in place, these diseconomies can't be passed on to patients. Additionally, the smallest practices were often, but not always, in the smallest communities where it was difficult to attract enough volume to support larger practices.

- **Clinics had a "typical" utilization of mid-levels**

  Among the seven "best financial practice" clinics, the ratio of mid-levels to physicians, at 7:1, was close to the overall sample. In the overall sample, there were several instances in which the ratio of mid-levels was greater than 1:1. These practices tended to underperform financially. At the other end of the continuum, there were several larger practices in which the mid-level ratios were below .2:1. These practices generally underperformed relative to the "best practices." It appears there is an efficiency balance to be struck in employing mid-levels. Because of their larger size, the best "best practice" RHCs were able to spread the cost of their mid-levels more broadly. For example, among the "best practices" mid-level costs were an average of $32,265/MD/FTE compared to $50,293 in the whole sample.

- **Clinics had much higher ratios of support FTE/Physician**

  Among the best practices there was an average of 4.08 support staff per physician and a median of 4.70. This contrasts to a median of 2.88 for the whole sample. Among US family practices, the median was 5.12. In Washington state, the median was 4.67. Best performers also had a higher proportion of total expense allocated to support staff. This pattern of richer support staff levels correlating to strong financial performance is generally true nationally among private practices. The additional staff, if used appropriately, extends the efficiency of the physician allowing him or her to see more patients. Additionally, some of these personnel are providing ancillary services which can be separately billed.

- **The majority of these clinics are multi-specialty**

  This observation is consistent with the observations of higher revenues/visit among the best practices, with larger clinic size, and with larger communities. Five of seven best practices were multi-specialty clinics and four of these combined primary and specialty care. Multi-specialty

organization was not a guarantee of financial success, however. In the overall sample, there were nine clinics with primary and specialty care combined and another six with multiple primary care specialties.

- **The majority of these clinics were classified as small town by RUCA**

  Of the seven best financially performing clinics, four were classified as small town (2,500-10,000); two were large town (10,000-50,000); and one was in an isolated area (under 2,500). This is consistent with the fact that it is financially most difficult to be successful in areas with low population densities.

- **All of these clinics were independent RHCs**

  This is partly a function of the four criteria chosen to select "financial best performers." These criteria are similar to benchmarks used nationally for private practices. In the interviews associated with this project, it was learned that often Hospital District ownership was a "last resort" option for communities which had a history of difficulty attracting or retaining physicians. The district structure, in part, provides a vehicle for subsidy to maintain otherwise non-viable practices. Many of these provider-based clinics see a role in providing care to the uninsured as a key part of their mission. Thus, financial performance is only one measure of success in meeting the RHC's mission.

- **Clinics had below average Medicare and Medicaid encounter rates**

  The average Medicare encounter rate was $64.78 compared to $96.13 for the overall sample. On the Medicaid side, the "best practices" had an average encounter rate of $82.94 compared to the whole sample at $86.78. The highest federal and state subsidies were generally targeted to the most financially stressed RHCs.

Observations

Table 13.1 Best Practices

Table 12.1 - Best Practices

CLINIC ID	Total Best Practices	Median Best Practices	Average Best Practices	Average All RHCs	Median all RHCs
Utilization Statistics					
Total visits	383,236	42,294	54,748	18,882	9,180.00
Total visits/MD FTE		5,667	5,534	5,424	5,126.00
Medicare visits	88,457	9,320	14,743	4,347	1,984.00
% Medicare visits		35%	34%	25%	25.00%
Medicaid visits	36,885	8,334	7,377	3,009	1,678.00
% Medicaid visits		17%	18%	22%	18.00%
Total Other visits	128,206	14,439	21,368	9,607	4,870.00
% Other visits		50%	51%	55%	53.00%
Financial Statistics					
Total medical revenue	$ 56,009,382.56	$ 5,253,857.00	$ 8,001,340.37	$ 227,015.84	$ 855,786.00
Total medical revenue/visit		$ 111.08	$ 120.41	$ 86.75	$ 87.88
Total medical revenue/MD FTE		$ 612,152.89	$ 644,942.94	$ 484,527.83	$ 471,499.44
Total support staff FTE cost	$ 17,304,057.00	$ 1,712,760.50	$ 2,472,008.14	$ 698,220.34	$ 280,256.00
Total operating cost	$ 31,427,026.00	$ 2,702,792.00	$ 4,489,575.14	$ 1,279,336.99	$ 552,984.00
Total operating cost/visit		$ 45.18	$ 61.52	$ 54.01	$ 49.70
Total operating cost/MD FTE		$ 276,492.00	$ 322,468.69	$ 291,632.27	$ 266,462.59
Total medical revenue after operating cost	$ 24,582,356.00	$ 2,551,065.00	$ 3,511,765.14	$ 887,388.33	$ 295,334.00
Ttl med. Rev after operating cost/MD FTE		$ 304,685.42	$ 322,474.22	$ 175,555.82	$ 166,789.50
Total midlevel cost	$ 1,389,878.00	$ 173,382.50	$ 198,554.00	$ 125,384.10	$ 81,727.00
Total midlevel cost/MD FTE		$ 22,625.45	$ 32,265.17	$ 50,292.64	$ 41,639.77
Total physician cost	$ 19,555,871.00	$ 1,946,573.50	$ 2,793,695.86	$ 808,481.87	$ 415,405.50
Total physician cost/MD FTE		$ 225,455.19	$ 236,680.54	$ 170,411.15	$ 176,361.00
Other revenue	$ 65,827.00	$ 32,913.50	$ 9,403.86	$ 19,540.47	$ 44,508.86
Other revenue/MD FTE	$ 11,043.18	$ 5,521.59	$ 1,577.60	$ 9,096.62	$ 24,864.08
Net Practice Income or loss	$ 3,308,489.00	$ 139,356.50	$ 472,641.29	$ 49,129.78	$ -
net Practice Income or loss/MD FTE		$ 30,501.50	$ 52,714.02	$ (13,887.25)	$ -
Overhead Rate			50%	65%	60%
Accounts Receivable					
% of Total AR 0 to 30 days		63%	58.69%	46.37%	50.50%
% of Total AR 31 to 60 days		12%	11.43%	15.82%	14.47%
% of Total AR 61 to 90 days		5%	4.32%	8.81%	8.18%
% of Total AR 91 to 120 days		3%	14.88%	9.34%	5.64%
% of Total AR over 120 days		17%	10.68%	19.77%	16.44%
Total % AR					
B&O as % of Total cost		9%	8.66%	14.50%	10.63%
Descriptive Variables					
# of MD FTE	79.57	8.85	11.37	3.87	2.8
# of Provider FTE	104.90	11.98	14.99	5.44	4
# of support FTE	483.66	59.80	69.09	20.41	11
Total support FTE/provider FTE	28.55	4.70	4.08	3.08	2.88
Total support FTE/MD FTE	42.58	6.33	6.08	3.84	4.66
support personnel exp. as % of ttl med.rev.			26%	33.59	33.00%
Medicare Encounter Rate		64.78	$ 64.78	$ 96.16	$ 75.64
# of years as RHC			5	6	6
Ownership Type					
Location Type					
Practice Type					
Hospital in Community					

Appendix A – Overall Study Methodology

Methodology

The Rural Health Clinic Initiative began with the Office of Community and Rural Health within the Washington Department of Health meeting with interested stakeholders to develop goals and objectives for the Rural Health Clinic Initiative. These stakeholders included the Rural Health Clinic Association of Washington, the Washington State Medical Association, the Washington State Hospital Association, the Association of Washington Public Hospital Districts, the two Area Health Education Centers and East West Consulting (a private consulting firm). OCRH then contracted with three agencies to conduct a study that would evaluate the Rural Health Clinic Program. Goals of the study contracted to East West Consulting were to quantitatively identify financial best practices and the range of financial positions for certified Rural Health Clinics in Washington. The Western Washington Area Health Education Center and the Eastern Washington Area Health Education Center were contracted to conduct on-site interviews with clinic managers, physicians and mid-level providers. With the aforementioned data to qualitatively identify the range of best practices in the areas of clinic policies and procedures, operations, staffing, clinic services, quality improvement and community access to primary care medical services. Part of this analysis also included an in-depth review of the role that Washington Rural Health Clinics have in the health care safety net. This appendix reviews the overall study methodology.

Primary Care Access and the Safety Net

To further understand the relationship of Rural Health Clinics and the importance of the Rural Health Clinic Services Act, a secondary source of data gathered by OCRH from the Department of Health was used. The data is gathered to determine primary care access for health care services and is used in the determination of Health Professional Shortage Area designation.

This data was regionally gathered from calendar year 2001 through 2003. Assistance was provided by local health jurisdictions for better understanding of access to primary health care services in their areas. During that time, data was gathered for 75% (21 out of 28) of the rural counties/regions in Washington. The individual provider data was collapsed to create a clinic/facility picture of access to care by

Medicare, Medicaid and the uninsured/self-pay recipients in rural Washington. This information will be reported by geographic variation.

Washington State's Rural Health Clinics

The Rural Health Clinic Initiative surveys were conducted in the summer and fall of 2003. At the time the surveys were conducted, 102 rural health clinics had been certified by Medicare and invited to participate in the initiative. The source of information was provided by the state Department of Health, Facilities & Licensing, (the agency that certifies Rural Health Clinics) and was cross-referenced with a list from the Office of Community and Rural Health. A list of the 102 clinics is provided in Appendix B, and a map of the RHCs in Washington is shown in Appendix C.

Eighty-five percent of the clinics completed the qualitative surveys. Forty-two percent (42%) of the clinics successfully completed the quantitative surveys. Several issues prevented clinics from participating in the financial quantitative survey. The primary issue is when multiple clinics have a common owner; the financial data is reported in a common cost report. This situation occurs with public hospital districts as owners as well as private clinics that have multiple sites. The information is difficult to identify on a single site basis. The most common reason cited by clinics that did not participate in the qualitative survey were recent changes in ownership. Clinics that chose to not participate in either survey indicated primarily a lack of time to complete the surveys. Surveys used for the process are provided in Appendixes I and J.

The Department of Health provided participation incentive funds to the Rural Health Clinic Association to use as they best identify. Suggested ideas were for continuing education or dues reduction to participating clinics.

Survey Process

Drafts of both the quantitative and qualitative surveys were introduced at the 2003 Annual Meeting of the Washington Rural Health Clinic Association meeting. The purpose of the surveys and the goals and objectives were discussed with the meeting attendees. In June, a letter endorsing the process was sent from the Dept. of Health, the Rural Health Clinic Association Board of Directors and the Washington Public Hospital District Association. The quantitative survey was enclosed with the letter. East West Consulting conducted additional outreach to clinics through emails and phone calls as follow-up to increase clinic participation. Clinic questions were clarified and answered.

The qualitative surveys were mailed to clinics in July with on-site interviews conducted by the two AHECs scheduled with clinic managers and primary care providers through October. The closing date for all surveys was October 31, 2003.

Data Analysis

Though rural health clinics can have many different characteristics, the data will be analyzed and cross-tabbed by three types of independent variables. The most common variables identifying rural health clinics are:

- Type of RHC designation.
- Hospital-Affiliated - Though hospital affiliated can indicate ownership by a hospital, a long term care facility or a visiting nurse service, in Washington, all hospital-affiliated clinics are owned by either public hospital districts (42%), non- profit hospitals (4%), for-profit hospitals (1%), or (2%) non-profit corporation.
- Non-Hospital-Affiliated - More than half of Non-hospital-affiliated rural health clinics in Washington encompass are for-profit independent practices (51%).
- Geographic Location - The report will discuss clinics that are frontier, remote, less remote and urban. Due to shifting population density, areas that have been previously rural are now in urban areas. Changing policy affects these clinics and will be addressed in the report.
- Clinic Size - The number of primary care physicians practicing at the clinic determines clinic size. The cross tabulations will be based on 2 or fewer physicians, 3 - 5 physicians, greater than 5 physicians.

These variables will be used as the predictors for differences within the large number of questions asked of the clinic participants. The objectives of this initiative are identified as follows:

- Clinic stability as related to financial performance and patient volumes;
- The provision of a more stable environment for health care professionals to maintain health care practices in rural environments due to the Rural Health Clinic Services Act;
- Access to primary health care services for the community including Medicare and commercial insured residents.
- The degree that Rural Health Clinics comprise the safety net in rural Washington communities, defined as access to primary health care services for Medicaid recipients and the uninsured.

Several indicators are used to establish correlation between Washington state RHCs and national benchmarks. Questions that correlate with the national Rural Health Clinic survey/analysis published in January 2003 by the Maine Rural Health Research Center are used for many of the qualitative responses. The quantitative analysis will also use national benchmarks established by the Medical Group Management Association (MGMA).

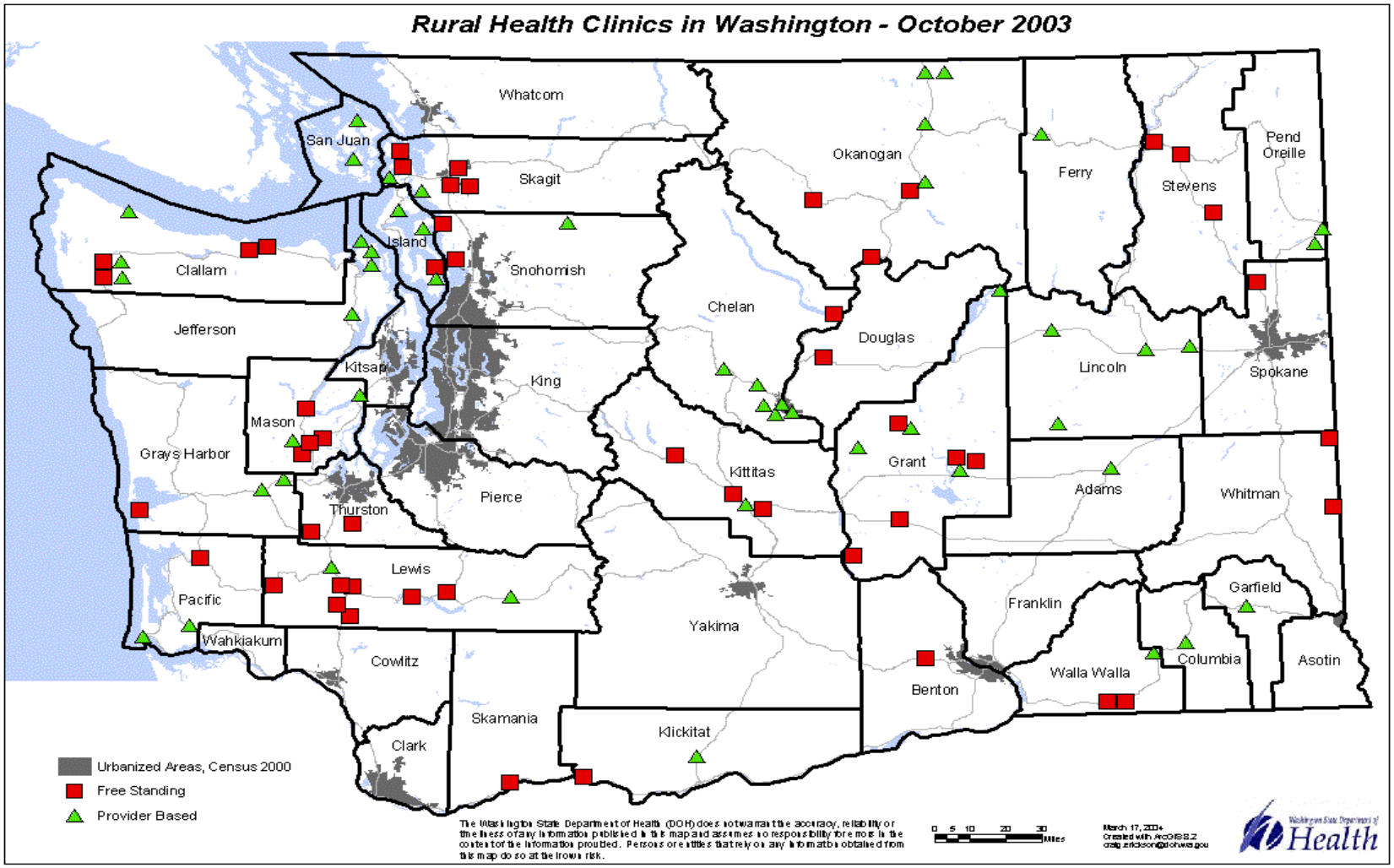
Appendix B - Rural Health Clinic List as of October 31, 2003

Facility Name	City	County	1st Yr Effective Date
Ritzville Medical Clinic	Ritzville	Adams	1994
Benton City Clinic	Benton City	Benton	1987
Cascade Medical Center	Leanvenworth	Chelan	1995
Cashmere Medical Center	Cashmere	Chelan	2002
Family Physicians	Wenatchee	Chelan	2000
Lake Chelan Clinic PC	Chelan	Chelan	1997
Wenatchee Valley Clinic	Wenatchee	Chelan	1996
Women's Healthcare Center	Wenatchee	Chelan	2000
Bogachiel Clinic	Forks	Clallam	2002
Clallam Bay Medical Clinic	Clallam Bay	Clallam	1978
Family Medical Center	Forks	Clallam	1991
Family Medical of Port Angeles	Port Angeles	Clallam	2002
Forks Women's Clinic	Forks	Clallam	1997
Peninsula Childrens Clinic Inc.	Port Angeles	Clallam	2002
Sol Duc Clinic	Forks	Clallam	1996
Columbia Family Clinic	Dayton	Columbia	1993
East Wenatchee Clinic	East Wenatchee	Douglas	1996
Waterville Clinic	Waterville	Douglas	1978
Republic Medical Clinic	Republic	Ferry	2002
Pomeroy Medical Clinic	Pomeroy	Garfield	1993
Association of Samaritan Physicians	Moses Lake	Grant	2001
Columbia Basin Family Medicine	Ephrata	Grant	1994
Coulee Community Hosp. & Immediate Care Clinic	Grand Coulee	Grant	1993
Ephrata Medical Center	Ephrata	Grant	2000
Mattawa Community Medical Clinic	Mattawa	Grant	1992
Moses Lake Clinic	Moses	Grant	1994
Parkview Pediatrics	Moses Lake	Grant	1997
Quincy Valley Medical Center	Quincy	Grant	1999
The Clinic at Royal City	Royal City	Grant	1999
Clinic at Elma	Elma	Grays Harbor	1995
Mark Reed Healthcare Clinic	McCleary	Grays Harbor	1996
The Beach Clinic	Westport	Grays Harbor	1995
Camano Community Health Clinic	Camano Island	Island	1999

Facility Name	City	County	1st Yr Effective Date
North Whidbey Community Clinic	Oak Harbor	Island	1996
South Whidbey Community Clinic	Clinton	Island	2000
The Langley Clinic	Langley	Island	2003
Jefferson General Medical Group	Port Townsend	Jefferson	2003
Olympic Primary Care	Port Townsend	Jefferson	2003
Port Townsend Family Physicians	Port Townsend	Jefferson	2003
South County Medical Clinic	Quilcene	Jefferson	1996
Cle Elum Family Medicine Center	Cle Elum	Kittitas	2002
Ellensburg Pediatrics	Ellensburg	Kittitas	2003
Family Health Care	Ellensburg	Kittitas	2003
Kittitas Valley Primary Care Associates	Ellensburg	Kittitas	2003
The Valley Clinic LLP	Ellensburg	Kittitas	2002
Family Practice Clinic	Goldendale	Klickitat	2002
Mid-Columbia Family Health Center/White Salmon	White Salmon	Klickitat	1994
Morton Medical Center PLLC	Morton	Lewis	2002
Mt. St. Helens Clinic-Onlaska	Onalaska	Lewis	2002
Mt. St. Helens Medical Clinic--Toledo	Toledo	Lewis	1991
Mt. St. Helens Medical Clinic--Winlock	Winlock	Lewis	1991
Napavine Medical Clinic	Navapine	Lewis	1994
Pe Ell Health Center	Pe Ell	Lewis	1996
Providence Health & Education Center	Chehalis	Lewis	2003
Randle Clinic	Randle	Lewis	2001
Riffe Medical Center	Mossyrock	Lewis	2001
Davenport Clinic	Davenport	Lincoln	2003
Odessa Clinic	Odessa	Lincoln	1991
Reardan Health Clinic	Reardon	Lincoln	2003
Wilbur Clinic	Wilbur	Lincoln	2003
Hoodsport Family Clinic	Hoodsport	Mason	2003
Mountain View Women's Health Center	Shelton	Mason	1997
North Mason Medical Clinic	Belfair	Mason	1995
Oakland Bay Pediatrics	Shelton	Mason	2002
Olympic Physicians	Shelton	Mason	1999
Shelton Family Medicine	Shelton	Mason	1999
Main Street Health Assoc. PS	Brewster	Okanogan	1998
Methow Valley Family Practice	Twisp	Okanogan	2001
North Valley Family Medicine	Tonasket	Okanogan	1997
Okanogan Valley Clinic PLLC	Omak	Okanogan	2000
Oroville Family Medical Clinic	Oroville	Okanogan	2002
Pioneer Medical Center	Oroville	Okanogan	1997
Wenatchee Valley Clinic/Omak	Omak	Okanogan	1994

Facility Name	City	County	1st Yr Effective Date
Naselle Clinic	Naselle	Pacific	1991
Ocean Beach Medical Clinic	Ilwaco	Pacific	1995
Riverview Health Clinic	Raymond	Pacific	1995
Family Health Center	Newport	Pend Oreille	2001
Family Medicine Newport	Newport	Pend Oreille	1989
Lopez Island Medical Clinic	Lopez	San Juan	1995
Orcas Island Medical Center	East Sound	San Juan	1995
Anacortes Family Medicine	Anacortes	Skagit	2000
Fidalgo Medical Associates PLLc	Anacortes	Skagit	2002
Island Family Physicians	Anacortes	Skagit	2000
La Conner Medical Center	La Conner	Skagit	2000
North Cascade Family Physicians	Mt. Vernon	Skagit	2002
North Cascade Internal Med/Sedro Woolley	Sedro Woolley	Skagit	2001
Skagit Valley Medical Center	Mt. Vernon	Skagit	2001
Mid-Columbia Family Health Center/Stevenson	Stevenson	Skamania	1994
Cascade Valley Darrington Clinic	Darrington	Snohomish	1997
Stanwood Medical Center	Stanwood	Snohomish	2001
Tulalip Tribes Health Clinic	Tulalip	Snohomish	1978
Deer Park Family Care Clinic	Deer Park	Spokane	2003
Chewelah Associated Physicians	Chewelah	Stevens	2001
Northeast WA Medical Group/Colville	Colville	Stevens	2001
Northeast WA Medical Group/Kettle Falls	Kettle Falls	Stevens	2000
Providence Rochester Family Medical Clinic	Rochester	Thurston	1996
Tenino Family Practice	Tenino	Thurston	2000
Blue Mountain Medical Group	Walla Walla	Walla Walla	2002
Waitsburg Clinic	Waitsburg	Walla Walla	1993
Walla Walla Clinic/Tietan	Walla Walla	Walla Walla	1997
Palouse Health Center	Palouse	Whitman	2003
Tekoa Medical Clinic	Tekoa	Whitman	1996

Appendix C - Rural Health Clinics Map



Appendix D - Glossary of Terms

Area Health Education Center (AHEC) – Washington has two AHECs.

Eastern Washington Area Health Education Center (EWAHEC) – Offers technical assistance to rural and urban underserved communities in eastern Washington State with an emphasis on health care workforce development. Facilitates the Locum Tenens program for OCRH and is a member of the Statewide Office of Rural Health (SwORH).

Western Washington Area Health Education Center (WWAHEC) – Offers technical assistance to rural and urban underserved communities in western Washington in health care workforce recruitment and retention and community development activities. Facilitates the Volunteer/Retired Provider Malpractice Insurance program for OCRH and is a member of the Statewide Office of Rural Health (SwORH).

Center for Medicare and Medicaid Services (CMS) – Federal agency responsible for the Medicare and Medicaid programs. Part of the U.S. Department of Health & Human Services. Previously known as the Health Care Financing Administration (HCFA).

Cost Report – Document prepared annually by each RHC at the end of the fiscal year. Used to reconcile RHC allowable costs and allowable visits with RHC payments.

Critical Access Hospital (CAH) – A federal designation designed to allow more flexible staffing options relative to community need, simplify billing methods, and create incentives to develop locally-integrated health care delivery systems.

Fiscal Intermediary (FI) – Company designated by CMS to process claims and make payment for services.

Federally Qualified Health Center (FQHC) – A type of provider defined by Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

Federally Qualified Health Center (FQHC) Look-Alike – An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant but does not receive grant funding.

Health Care Financing Administration (HCFA) – See Centers for Medicare and Medicaid Services (CMS).

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal regulations to be followed by health plans, doctors, hospitals and other health care providers, especially involving confidentiality of patient information and documentation of privacy procedures.

Health Professional Shortage Area (HPSA) – Federal designation for a county or sub-county area. Used to determine eligibility for various federal programs. Shortage can be designated for primary care, primary dental care, and/or mental health care.

Hill-Burton Act - Congress enacted the Hospital Survey and Construction Act (Public Law 79-725), known as the Hill-Burton Act, in 1946. According to *Health Care in Rural America*, about 30 percent of all hospitals built between 1949 and 1962 used Hill-Burton monies.

Interim Payment Rate – Medicare all-inclusive rate calculated by dividing the Medicare allowable costs by number of Medicare allowable encounters. Each RHC receives this amount for each Medicare covered RHC visit through the clinic's fiscal year. At the end of the fiscal year, payments for the year are reconciled based on a cost report. The interim payment rate is recalculated annually.

J1 Visa doctors – A state-managed, federal program that waives an immigration requirement that non-US citizens graduating from medical school return to their home countries at the end of their education. The waiver is in exchange for three years of service in a Health Professional Shortage Area.

Local Health Department or District – Washington has 35 local health departments/districts. They are local government agencies, not satellite offices of the state Department of Health or the State Board of Health. Local health departments carry out a wide variety of programs to promote health, help prevent disease and build healthy communities. Also known as Public Health Department or District (PHD).

Medical Assistance Administration (MAA) – A division within the Department of Social and Health Services that oversees state Medicaid programs.

Medical Group Management Association (MGMA) – The national membership association for individuals who manage and lead medical group practices.

Medically Underserved Area (MUA) – Federal shortage designation for primary care. Used to determine eligibility for various federal programs. Based on ratio of primary medical care physicians per

1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

Medicare Economic Index (MEI) – Medical inflation rate. Used to adjust reimbursement caps on annual basis.

Office of Community and Rural Health (OCRH) – An office within the Washington state Department of Health that is Washington's Office of Rural Health and houses the Primary Care Office, Loan Repayment and Scholarship program, HPSA designation process, Critical Access Hospital program, and primary care recruitment and retention activities; and provides technical assistance to rural health stakeholders. A member of the Statewide Office of Rural Health (SwORH).

Provider Identification Number (PIN) – Unique number issued by payers to each provider to identify that provider as a credentialed and approved provider. Also known as a Medicare billing number.

Public Health Department or District (PHD) – See Local Health Department or District.

Quality Assessment and Performance Improvement (QAPI) Program – Required by the CMS as a condition of participation for Medicare. A QAPI program must be hospital-wide, ongoing, and focused on indicators related to the improvement of health outcomes.

> *QAPI focuses provider efforts on the actual care delivered to patients, the performance of the hospital as an organization, and the impact of treatment furnished by the hospital on the health status of its patients. Specifically, it is important to note that a QAPI is not designed to measure a hospital's quality, but rather a minimum requirement that the hospital systematically examine its quality and implement specific improvement projects on an ongoing basis…. In addition, the QAPI entails all activities required for measuring quality of care and maintaining it at acceptable levels.*
>
> – From CMS 3050-F, Published Regulations on QAPI, January 24, 2003.

Resource-Based Relative Value Scale (RBRVS) – A component of Medicare and Medicaid standardized physician reimbursements. The cost of providing each service is divided into three components: physician work (52%), practice expense (44%) and professional liability insurance (4%). Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid Services). Payments are also adjusted for geographical differences in resource costs. The CMS is required to review the whole scale at least every five years.

Rural Urban Commuting Area (RUCA) Codes - A detailed and flexible scheme that identifies areas of emerging urban influence and areas where settlement classifications overlap. As of 2000 there were 10 RUCA classifications, including Metropolitan (numbers 1-3), Micropolitan (4-6), Small Town (7-9) and Rural (10).

Rural Health Clinic (RHC) – A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. RHCs must be located in underserved rural areas and provide primary care services. RHCs use a team approach of physicians, nurse practitioners, physician assistants, and certified nurse midwives to provide services.

Independent (Non-HA) – A designation of Rural Health Clinic ownership by a health care practitioner; can be non-profit or for-profit and is sometimes referred to as freestanding.

Provider-based (HA) – A designation of Rural Health Clinic ownership by a health care business including a hospital, long term care facility or home health agency; can be a for-profit or non-profit business.

Safety Net – One definition of Safety Net Providers is provided by the Institute of Medicine in their report on America's Health Care Safety Net (Lewin & Aultman, 2000):

> *Safety net providers are providers that deliver a significant level of care to uninsured, Medicaid, and other vulnerable patients. In its report, the committee focuses on "core safety net providers." These providers have two distinguishing characteristics:*
>
> 1. *either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and*
> 2. *a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients.*
>
> *Core safety net providers typically include public hospitals, community health centers, and local health departments, as well as special service providers such as AIDS and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety net providers.*

Statewide Office of Rural Health (SwORH) – A partnership of the State Department of Health, Western Washington Area Health Education Center, University of Washington School of Medicine, Washington State University, and Eastern Washington Area Health Education Center. This partnership was created to establish a formal primary relationship among these organizations for the purposes of

disseminating information, consulting, and deliberating on matters pertinent to the goals of the Office of Rural Health.

Unique Provider Identification Number (UPIN) – Six-character alphanumeric identifier assigned to all Medicare physicians, medical groups and non-physician practitioners.

Appendix E - How to Become a Rural Health Clinic

This checklist will help guide your clinic to become certified as a Rural Health Clinic (RHC) under the Medicare program. There are three main steps to become certified as a RHC. Each step is comprised of many elements. All steps must be met before RHC certification is granted. If you have any questions contact:

Laura Olexa
Department of Health
Office of Community and Rural Health
PO Box 47834
Olympia, WA 98504-7834
Phone: 360-236-2811
Fax: 360-664-9273
Laura.Olexa@doh.wa.gov

☐ Step # 1 – Establish Initial Eligibility

Clinics are eligible if they:

☐ **A.** Are located in a rural or non-urbanized community as defined by the Census Bureau. The Office of Community and Rural Health (OCRH) will request verification of your clinic's location from Centers for Medicare and Medicaid Services (CMS).

☐ **B.** Are located within a federally designated primary care Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA). **This designation must be current within three (3) years of the date of the clinic's on-site survey.**

☐ Step #2 – Prepare for On-site Survey

Lynda Timothy, RN, MS (360-951-2131) from OCRH will be in contact you to provide assistance in preparing for the on-site survey. All steps must be completed prior to the survey being scheduled by Facilities and Services Licensing (FSL).

☐ **A.** Review on-site survey criteria including:
- Rural Health Clinic Medicare Regulations (current)
- Rural health Clinic Survey Report Form – CMS 30
- Appendix G Rural Health Clinic Interpretive Guidelines

☐ **B. CMS 855 – General Enrollment form.** You need to request this form from one of the fiscal intermediaries listed below. Simply fill out the CMS 855 **and *return it to the fiscal intermediary*** *for processing.* Processing of this form can take up to 60 days. No survey will be scheduled until the fiscal intermediary has submitted your form to Facilities and Services Licensing (FSL). Please note: FSL has 60 days from receipt of your CMS 855 form with which to schedule your survey.

For clinics that are **freestanding**:
Riverbend GBA
730 Chestnut Street, Room 3C
Chattanooga, TN 37402-1790
1-423-755-5124

For clinics that are **provider based**:
Noridian Mutual Insurance Company
PO Box 6700
Fargo, ND 58108
1-888-608-8816

☐ **C.** Employ a medical director available to provide patient care at least once in every two-week period.

☐ **D.** Employ a nurse practitioner, certified nurse midwife or physician assistant to provide care at least 50% of the time the clinic is open.

☐ **E.** Identify an individual in the clinic who is responsible to assure that all the Medicare Conditions of Participation are met as listed in the Rural Health Clinic Regulations. This designated individual should be thoroughly versed in all of the RHC Conditions of Participation and all aspects of clinic services.

☐ **F.** Develop a RHC manual that includes all required policies, procedures and protocols as listed in the Rural Health Clinic Regulations.

☐ **G.** Develop written job descriptions for the physicians and mid-level practitioners. Be sure the job descriptions include responsibilities for policy and procedure development and participation in program evaluation activities.

☐ **H.** Review all employee file information for evidence of current licensure, DEA number for professional providers and other required certification and training.

☐ **I.** Determine if the clinic's physical plant and environment meet all federal, state and local safety and maintenance requirements as listed in the Rural Health Clinic Regulations. This includes medication management systems, fire & safety codes, physical plant maintenance, storage of cleaning supplies, patient care equipment calibration & maintenance, etc.

☐ **J.** Assure the clinic is able to provide all six required lab tests on the clinic's premises and have appropriate MTS/CLIA waiver available for surveyor to review during onsite survey. Go to http://www.doh.wa.gov/hsqa/fsl/LQA_Home.htm for MTS (medical test site) waiver information and application.

☐ **K.** Develop a written program evaluation or quality improvement program that meets the requirements listed in the Rural Health Clinic Regulations.

☐ **L.** Make all necessary actions to assure the clinic meets all of Conditions of Participation as listed in the Rural Health Clinic Regulations.

☐ Step # 3 – On-Site Survey

☐ **A.** After **all** the requirements in Step #2 have been met complete and submit the following forms to Laura Olexa (contact information can be found above):

- Request for On-Site Survey
- Request to Establish Eligibility – CMS 29
- Health Insurance Benefits Agreement – CMS 1561A (*three copies with **original signatures on each***)

☐ **B.** A Facility and Services Licensing Surveyor will contact you to verify that you consider your clinic meets all of the Medicare Conditions of Participation and to schedule the on-site survey. If you have any questions about your surveyor, contact Raejean Bales at 360-236-2917.

☐ **C.** Upon completion of the on-site survey your clinic will receive a written report indicating if the clinic meets all the Conditions of Participation and a recommendation from the State that the clinic be approved to participate in the Medicare RHC program. If the clinic is found to have any deficiencies corrections must be made before the clinic is recommended for approval. **NOTE: If the clinic does not meet one or more of the Medicare Conditions of Participation the clinic cannot be certified. You will be given an opportunity to resolve these deficiencies within a reasonable amount of time before being surveyed again.**

☐ **D.** Survey information is forwarded to CMS Region X office in Seattle by FSL with a recommendation for approval to participate in the Medicare Rural Health Program. CMS is responsible for the final certification decision.

☐ **E.** CMS Region X office will notify the clinic of approval status, within 30 days, of the clinic's Medicare provider number and effective date. That office may be contacted at: (206) 615-2321.

☐ **F.** The clinic contacts the fiscal intermediary regarding billing instructions after receiving the provider number.

☐ **G.** The Department of Health - FSL will make periodic **unannounced** inspections to assure the clinic continues to meet all Medicare Conditions of Participation.

Appendix F - Rural Health Clinic Resources

Area Health Education Center (AHEC) –
Eastern Washington Area Health Education Center (EWAHEC) – (509) 358-7640
Email – ahec@wsu.edu
Web Site – www.ahec.spokane.wsu.edu

Western Washington Area Health Education Center (WWAHEC) –
(206) 441-7137
Email – wwahec@wwahec.org
Web Site – www.wwahec.org

Medical Assistance Administration (MAA) – (360) 902-7604
Email – contact forms are available at
http://fortress.wa.gov/dshs/maa/contact/contactus.htm
Web Site – http://fortress.wa.gov/dshs/maa/

National Association of Rural Health Clinics (NARHC) – (515) 280-1944
Email - info@narhc.org
Web Site – www.narhc.org

National Rural Health Association (NRHA) – (816) 756-3140
Email – mail@NRHArural.org
Web Site – www.NRHArural.org

Washington Office of Community and Rural Health (OCRH) – (360) 236-2800
Email - crhmail@doh.wa.gov
Web Site – www.doh.wa.gov/hsqa/ocrh

Rural Assistance Center (RAC) – (800) 270-1898
Email – info@raconline.org
Web Site – www.raconline.org

Statewide Office of Rural Health (SWORH) – (360) 236-2800
Email - crhmail@doh.wa.gov
Web Site – www.doh.wa.gov/hsqa/ocrh

Washington Academy of Family Physicians (**WAFP)** – (425) 747-3100
Email – admin@wafp.net
Web Site – www.wafp.net

Washington Association of Community and Migrant Health Centers (WACMHC) – (360) 786-9722
Email – info@wacmhc.org
Web Site – www.wacmhc.org

Association of Washington Public Hospital Districts (AWPHD) – (206) 281-7211
Email –contact form is available at http://www.awphd.org/contact.asp#
Web Site – www.awphd.org

Washington Health Foundation (WHF) – (206) 285-6355
Email - JulieD@whf.org
Web Site – www.whf.org

Washington Rural Health Association (WRHA) – (509) 358-7653
Web Site – www.wrha.com

Rural Health Clinic Association of Washington (RHCAW) – (509) 489-4524
Web Site: www.rhcaw.net

Washington State Hospital Association (WSHA) – (206) 281-7211
Email – A list of WSHA staff and their email links is available at http://www.wsha.org/about_staff.htm
Web Site – www.wsha.org

Washington State Medical Association (WSMA) – (206) 441-9762, (800) 552-0612
Email – contact form is available at http://www.wsma.org/scripts/contact.cfm
Web Site – www.wsma.org

Appendix G - Financial/Utilization Survey Instruments

NOTE: DEFINITIONS FOR ALL ITEMS ARE INCLUDED IN THIS PACKET.

2002 FISCAL YEAR DEFINITION

All the questions on this questionnaire refer to the **2002** fiscal year. This is typically January through December 2002. If your practice uses an alternative fiscal year, you are encouraged to use it in your responses.

1. For the purposes of reporting the information in this questionnaire, what fiscal year was used? (fill in the blanks)

Beginning month	Beginning Year
Through ending month	Ending Year

2. What was your practice type (check only one)

Single specialty
Multi-specialty with primary and specialty care
Multi-specialty with primary care only
Multi-specialty with specialty care only
If you stated single specialty, which specialty is this?
_____

3. What accounting method was used for tax reporting purposes? (Check one)

Cash
Accrual

4. What accounting method was used for internal management purposes? (Check one)

Cash or Modified Cash
Accrual

SUMMARY OF MEDICAL CHARGES AND REVENUE

PLEASE PROVIDE THE FOLLOWING TOTALS IN THE INDICATED SPACE BELOW

5. Total gross charges:

$

6. Total medical revenue:

$

7. Total Support Staff

Total support staff FTE

Total support staff FTE cost $

8. Total general operating cost:

$

9. Total operating cost: *line (8) + line (7)*

$

10. Total medical revenue after operating cost: *line (6) – line (9)*

$

11a. Total midlevel provider FTE:

11b. Total midlevel FTE cost:

$

12a. Total physician FTE:

12b. Total physician FTE cost:

$

13a. Total provider FTE: *line (11a) + line (12a)*

13b. Total provider cost: *line (11b) + line (12b)*

$

14. Net non-medical revenue:

$

NET PRACTICE INCOME OR LOSS

15. Net practice income or loss: *line (10) – line (13) + line (14)*

$

UTILIZATION

16a. Visits in office or patient's home (include visits of both RHC and non-RHC patients)**:**

16b. Visits in a hospital, or nursing home setting(include visits of both RHC and non-RHC patients)**:**

16c. Total visits in office/clinic, home, hospital or nursing home: line (16a) + line (16b)

17. Total Medicare visits:

18. Total Medicaid visits (exclusive of healthy options):

19. Total Healthy Options visits:

20. Total Basic Health Plan visits (includes BHP+):

21. Total all other visits: *line (16c) - (17) - (18) - (19) -(20)*

ACCOUNTS RECEIVABLE

22. Accounts Receivable:

Please provide the information regarding the age of your practice's accounts receivable at the end of your fiscal year. Do not include accounts that have assigned to collection agencies. Definitions are attached for your reference. If you are unable to provide AR

for the end of your fiscal year, please provide current AR and check the appropriate box below. Please provide Accounts Receivable (AR) in dollars by age category. This is for your entire organization. It does not have to be broken out by site or category; rural health clinic vs. other services.

Current to 30 days..... $
31 to 60 days ..... $
61 to 90 days..... $
91 to 120 days ..... $
Over 120 days ..... $
Total accounts receivable (add all lines) $

The Account Receivable (AR) data above are for: ***(Please check one)***

	Last fiscal year end
	Current or other time period

Completed by:
Clinic Name: _____

Name: _____ Date: _____
(Please print)

RHC STAFFING TABLE

This table refers to RHC providers only

1. Medical Service by specialty:

Specialty	Name of Provider	FTE
1:		
2:		
3:		
4:		
5:		
6:		
7:		
8:		
9:		
10:		

2. Mid level providers:

Mid level Type	Name	FTE
1:		
2:		
3:		
4:		
5:		

3. Dental Services: Name FTE

a) Dentists
b) Dental Hygienists
c) Dental Assistants, Aides, Technicians, Support

4. Mental Services Name FTE

a) Mental Health and Substance Abuse Specialists
b) Mental Health and Substance Abuse Support

5. Medical Clinic Support Staff: FTE (Please provide the total full-time equivalent (FTE) support staff—to the nearest tenth FTE—in the FTE column. **This includes *ALL* staff, not only RHC staff.)**

		FTE
a	General administrative (administrators, chief financial officers, medical director, human resources, marketing, purchasing)……	
b	Business office (business office manager, billing, accounting, bookkeeping, collections)……	
c	Managed care administrative (HMO/PPO contract administrators, quality assurance, utilization review, case management)……	
d	Information technology (data processing, programming, telecommunications)……	
e	Housekeeping, maintenance, security……	
f	Medical receptionists……	
g	Medical secretaries, transcribers……	

h	Medical records……
i	Other administrative support……
j	Registered Nurses……
k	Licensed Practical Nurses……
l	Medical Assistants……
m	Nurse's Aides……
n	Clinical laboratory (laboratory manager, nurses, secretaries, technicians)
o	Radiology and imaging (radiology manager, nurses, secretaries, technicians)……
p	Other medical support services (services in all ancillary departments other than those listed above such as optical, physical therapy, etc.)….
q	Total employed support staff FTE (Add lines from line A to line P)…….
r	Total contracted support staff (temporary)……
s	Total Support staff (For Total support staff FTE add lines for line Q to line R, FTE column)

DEFINITIONS TO COST SURVEY

2002 Fiscal Year Definition:

1. **For the purpose of reporting the information in this questionnaire, what fiscal year was used?**
   For many practices, this is January 2002 through December 2002. If your practice uses an alternative fiscal year, you are encouraged to use it in your responses. Do not report data for periods less than 12 months.

2. **Medical Practice Information**
   What was your practice type for your clinic including its RHC portion or activity? (Check one only)
   Single Specialty: A medical practice that focuses its clinical work in one specialty.
   Multi-specialty with primary and specialty care: A medical practice which consists of physicians practicing in different specialties, including at least one

primary care specialty family practice, general internal medicine, geriatrics, or general pediatrics).

Multi-specialty with primary care only: A medical practice that consists of physicians practicing in more than one of the primary care specialties if family practice, general internal medicine, geriatrics, general pediatrics, or the surgical specialty of obstetrics/gynecology.

Multi-specialty with specialty care only: A medical practice, which consists of physicians practicing in different specialties, none of which are the primary care specialties (family practices, general internal medicine, geriatrics, or general pediatrics).

3. and 4. What accounting method was used for tax and management Reporting purposes?

CASH: An accounting system where revenues are recorded when cash is received and costs are recorded when cash is paid out. Receivables, payables, accruals and deferrals arising from operations are ignored.

ACCRUAL: An accounting system where revenues are recorded as earned when services are performed rather than when cash is received. Cost is recorded in the period during which it is incurred, that is, when the asset or service is used, regardless of when cash is paid.

5. Total Gross Charges: The full value, at the practice's undiscounted rates, of all services provided to all clinic patients whether capitated or fees-for-service. Include:

- o professional services;
- o ancillary services such as laboratory and radiology (both professional and technical components); and
- o Contractual adjustments and write-offs.

6. Total Medical Revenues: The amount collected, after discounts and adjustment, for all medical services provided by this practice.
Include:

- o net fees-for-service collections;
- o net capitation revenue; and
- o Net revenue from the sale of medical goods and services.

7. Total Support Staff FTE and Cost:

FTE: For this purpose support staff are all personnel *other than* physicians (M.D. and D.O.) and mid-level providers employed by all the legal entities working in support of the entities represented on this questionnaire. Mid-levels are specially trained and licensed personnel who can provide medical care and billable services.

An FTE is the full time equivalency of each individual. Thus a half time MA is a 0.5 FTE, for example.

Support Cost: Include salaries, bonuses, incentives, voluntary employee deductions and benefits.

8. Total General Operating Cost:

DO **NOT** include:

- Support staff cost
- Midlevel provider cost

Do include:

- Information technology
- Medical and surgical supply
- Building and occupancy
- Furniture and equipment
- Administrative supplies and services
- Professional liability insurance premiums
- Other insurance premiums
- Outside professional fees such as legal and accounting
- Promotion and marketing
- Clinical laboratory
- Radiology and imaging
- Other ancillary services
- purchased billing and collections services
- Management fees
- Miscellaneous operating cost
- Cost allocated to medical practice from parent organization

9. Total Operating cost: This is the sum of line (8) plus the expense on line (7).

10. Total Medical Revenue after operating cost: This is line (6) minus line (9).

11a. Total midlevel provider FTE: for a definition of midlevel and of FTE see line (7).

11b. Total midlevel FTE cost: Cost includes all compensation plus benefits.

12a. Total physician FTE : For a definition of FTE please see line (7).

12b. Total physician FTE cost: Compensation includes salaries, bonuses, incentives, voluntary payroll deductions. Benefits include employer's share of tax, health, disability, life, L & I. Also include employer payments to retirement plans, deferred compensation plans, dues and memberships.

13a. Total Provider FTE: This is the sum of line (11a) and (12a)

13b. Total Provider FTE cost: This is the sum of line (11b) and (12b)

14. Net Non-Medical revenue:

Include:

- Interest and investment revenue;
- Gross rental income;
- Capital gains; and
- Operating support from a parent entity.

Subtract from gross non-medical revenues:

- Amortization of practice acquisition and goodwill;
- Income tax and other tax based on net or gross profit;
- Cost required to maintain non-medical income producing property; and
- Capital losses.

15. Net Practice Income or Loss:

This is line (10) minus line (13) plus line (14).

16a. Visits in office or patient's home (include visits of both RHC and non-RHC patients)**:**

Face to face encounter for a medically necessary service with a physician, physician assistant, nurse practitioner, nurse midwife, psychologist or social worker that takes place in a rural health clinic or at the patient's home. This categorization of visits includes the rural health clinic definition, plus non-rural health patients such as commercial patients.

16b. Visits in a hospital, or nursing home setting(include visits of both RHC and non-RHC patients)**:** Face to face encounter between a provider (physician or mid-level provider) and patient that takes place in a hospital(including ER) or nursing home setting.

16c. Total visits in office/clinic, home, hospital or nursing home: line (16a) + line (16b)

17. Medicare visits:

The proportion of line (16c) attributable to Medicare whether fee-for-service or other payment sources such as capitation.

18. **Medicaid/Visits:** The proportion of line (16c) attributable to Medicaid whether payment is received from MAA (DSHS) or from a third party payor. ***DO NOT*** include Healthy Options of BHP+.

19. **Healthy Options Visits:** The proportion of line (16c) attributable to Healthy Options patients whether payment is received from MAA (DSHS) or from a third party payor.

20. **Basic Health Plan Visits**: The proportion of line (16c) attributable to Basic Health Plan (BHP) patients whether payment is received from the State or from a third party payor. Include BHP+ here.

21. **All Other visits:** This is line (16c) - (17) - (18) - (19) – (20).

22. Accounts Receivable (AR): Amounts owed to the practice by patients, third-party payers, employer groups etc. for fee-for-service activities before adjustments for anticipated payment reductions or bad debts. A charge is assigned to "accounts receivable" at the time an invoice is submitted to a payer or patient for payment. Deletion from AR occurs when the account is paid, turned over to a collection agency or written off as bad debt. This is for your entire organization. It does not have to be broken out by site or category or rural health clinic vs. other clinics.

Appendix H - Operational/Access Survey Instrument

Observational Questions For Rural Health Clinic survey
(to be noted by the AHEC interviewer) NOT to be asked.

Rural Health Clinic Name _____

1. With the address on record, was the clinic easily found?

Yes				No
1	2	3	4	5

2. Is there good signage to locate and identify the clinic?

Yes				No
1	2	3	4	5

3. Does the clinic have a clean, well-maintained exterior appearance?

Yes				No
1	2	3	4	5

4. Does the clinic have a clean, attractive waiting area?

Yes				No
1	2	3	4	5

5. While in the waiting room, could you hear or see information about individual patients?

Yes				No
1	2	3	4	5

6. Overall, does the clinic space seem adequate or crowded?

Adequate				Crowded
1	2	3	4	5

7. Additional Comments:

Rural Health Clinic Initiative

Qualitative Interviews

Rural Health Clinic Name: _____
Date _____

Clinician Interview

Clinician Name: _____

1. What year did you come to work at the clinic? _____
2. a) How many patients do you want to see in a day? _____
   b) How many do you presently see? _____
   c) On a scale of 1 to 5 with 1 being overwhelmed and 5 being bored, where do you fit?

1 2 3 4 5

3. a) Do you have an adequate number of support staff
   Yes ___
   No ___
   b) Do you feel they are adequately trained?
   Yes ___
   No ___
4. Are you comfortable seeing the patient mix that you presently have?
   Yes ___
   No ___
5. Do you have any need for advanced training in order to care for your patients as you would like?
   Yes ___ *(If yes, list)* _____
   No ___
6. a) Do you have hospital admitting privileges?
   Yes ___
   No ___
   b) Where? _____
7. Do you provide patient care outside of this facility? *(e.g. nursing home)*
   Yes ___ Where? _____
   No ___
8. Do you have adequate equipment and supplies?
   Yes ___
   No ___

9. Do you use a PDA or other electronic drug and patient information?
   Yes ___
   No ___

10. Does the medical staff have a decision-making role in
    a) clinical operations?
    Yes ___
    No ___
    b) in management?
    Yes ___
    No ___
    c) fiscal decisions?
    Yes ___
    No ___
    d. community outreach activities?
    Yes ___
    No ___
11. a) Do you have email?
    Yes ___
    No ___
    b) What is your email address? *(Is this your private address?)*
    _____ Private? ___
12. a) Do you have access to the Internet at work?
    Yes ___
    No ___
    b) At home?
    Yes ___
    No ___
13. What do you use the internet for?
    a) Drug information and interactions ___
    b) Patient information ___
    c) Specific disease information ___
    d) Library searches ___
    e) Other ____ *List* _____

Management Staff Interview:

Interviewee Name _____

A. Background and history

1. When was the clinic first opened? _____
2. When was the present building built? _____

3. We have that the clinic was certified as a Rural Health Clinic in _____. Is this correct?
Yes ___
No ___
3b. When did you start receiving enhanced reimbursement? _____
4. We also show that the clinic is owned by_____. Is this correct?
Yes ___
No ___ If no, list owner _____
5. a) When did you come to work at the clinic? _____
b) What was your prior training?
6. What is your role?
7. How does the Clinic do recruitment?
a) for professional staff?
Washington Recruitment Group ___
Professional Recruiter ___
Current Providers ___
Word of Mouth ___
Advertisements ___
Journal ad ___
Other _____*(list)*
b) for support staff?
Current Providers ___
Word of Mouth ___
Advertisements ___
Other _____*(list)*
8. Do you presently have vacancies?
a) for clinical staff?
Yes ___,
No ___
If yes:
i. For which discipline(s)? _____
ii. How many vacancies? ___
iii. Length of vacancy(ies) _____
b) for support staff?
Yes ___
No ___
9. What kinds of barriers or challenges are you finding to filling vacancies?
Recruitment costs ___
Time for Recruitment Activities ___
Salary ___
Schedules ___ *(call, etc.)*
No one wants to come ___
Other ___ *(list)* _____

B. Clinic Activity

1. This is a list of clinic services that was sent to you. Do you have any questions about how you've filled it out? (Table 1).

C. Staffing

1. This is the Personnel Inventory at your clinic which was sent to you earlier. (Table 2) Are there any questions about it or changes we need to make?
2. What hours and days is the clinic open for patients?

Hours _____

Days _____

3. a) Do any of the clinicians take call at a hospital?

   Yes ___

   No ___

   b) How often? _____

4. a) Is there a system of non-provider staff evaluations in place?

   Yes ___

   No ___

   b) How often are they done? _____

   c) Who does them? _____

5. a) What do you do for interpreter services?

   b) What languages are you needing interpreters for?

_____

   c) Do you have access to certified interpreters?

   Yes ___

   No ___

D. Data Management

1. Do you use a computer to keep track of data?

   Yes ___

   No ___

2. Do you have an electronic medical record?

   Yes ___

   No ___

3. a) Is your clinic linked to other health care information systems *(e.g. Meditech*)?

   Yes ___ Name _____

   No ___

   b) Are your computers linked with other computers in the office?

   Yes ___

   No ___

4. What kind of electronic clinical data do you keep on patients? *(e.g. Diabetes, asthma)*

_____

5. a) What is your practice management software?
_____
   b) Does it adequately provide all the reports and functions you need?
   Yes ___
   No ___
6. How many individual *(active, unduplicated)* patients does the clinic have?
7. Do you archive patient files?
   Yes ___
   No ___
8. a) Do you have a sliding fee scale?
   Yes ___ *(If yes, get a copy.)*
   No ___
   b) Where is it posted? _____
9. Where do you seek assistance for billing, coding or computer questions?

E. Contractual Arrangements

1. Who do you have contracts with?
   Group Health ___
   Medicaid ___
   Premera ___
   Molina ___
   Community Health Plan of Washington ___

Other Employer plans: _____
Basic Health Contractor(s):_____
Healthy Options
Contractor(s):_____
Medicaid:
_____

2. Are you taking new Medicare patients*? (Note: Do NOT count transition patients as new. e.g. current patient who turns 65 and is now Medicare)*
   Yes ___
   No ___
   if no, ask:
   i. When did you cease taking new Medicare patients? ____
   ii. Why? _____
3. Are you taking new Medicaid patients? *(NOTE: Do NOT count transition patients as new .e.g. current patient who loses job and goes on Medicaid.)*
   Yes ___
   No ___
   if no, ask:
   i. When did you cease taking new Medicaid patients? ____
   ii. Why? _____
4. Have you discontinued seeing patients or dropped contracts in any other category?

Yes ___
No ___
Basic Health ____
Healthy Options ___
Other ___
If yes, ask:
i. When did you cease taking these patients? ____
ii. Why? _____

5. Do you bill electronically?
Yes ___
No ___
6. a) What percent of claims are clean? _____
b) Are your clean claims paid promptly? How many days for worst?_____Best? _____
7. Does the clinic have management services or supply contracts (i.e. custodial, bookkeeping, medical records, payroll service or office support)?
Yes ___
No ___
If yes, list.
8. Do you have HIPAA agreements with all of your contractors?
Yes ___
No ___

F. Administration

1. a) Who is in charge at the clinic? _____
b) Does this person do day-to-day management?
Yes ___
No ___
(If no, get name of person who does day-to-day management)
2. Does your clinic have a Board of Directors, Advisory Board or Governing Board?
Yes ___
No ___
3. What kind of community outreach do you do? *(i.e. education, screening, newspaper articles, health fairs, etc.)*
4. a) Who/what do you see as competition for your RHC?
b) What kind of relationship, if any, do you have with them?
c) Is there a Community Health Center (CHC) or Federally Qualified Health Center (FQHC) in your community?
Yes ___ *(Name _____)*
No ___
5. With what local hospital(s) do you have transfer agreements?
_____

6. a) What ambulance service do you utilize if you need to transfer patients?
   _____
   b) What is their response time to your clinic? _____
7. a) Is the EMS system in the area satisfactory?
   Yes ___
   No ___
   b.) Does the clinic participate in EMS or EMS Council activities?
   Yes ___
   No ___
8. Has the clinic participated in BioTerrorism and smallpox planning, training or activities?
   Yes ___
   No ___
9. a) Does the Clinic have a Strategic Plan?
   Yes ___
   No ___
   b) *If yes*, who participated in creating it?
   _____
   c. When was it last updated? _____
10. Does the Clinic have a plan for capital improvements?
    Yes ___
    No ___

G. Quality Improvement

1. a) Do you have a patient satisfaction survey?
   Yes ___
   No ___
   b) How and when is it used?
2. Who handles customer complaints? _____
3. How is credentialing done for the clinic?
4. How do you deal with medical errors, drug errors, etc.?
5. Does the Clinic have a process for ensuring that all patients are up-to-date on their immunizations?
   Yes ___
   No ___
5. How do new ideas get considered by the organization?
6. a) Describe any formal quality improvement efforts you have in place.
   b) How about informal efforts?
7. a) Where do you obtain your malpractice liability coverage?
   _____
8. Where do you obtain your property liability coverage?
   _____

9. Do you obtain professional liability risk management training? *(e.g. from your insurance company)*
   Yes ___
   No ___
10. Do you have a State Certified Quality Improvement Plan? (QPIC)
   Yes ___
   No ___

H. Pharmacy

1. Does your clinic have an in-house pharmacy?
   Yes ___
   No ___
2. Have patients expressed to you any difficulties in getting their prescriptions?
   Yes ___
   No ___
3. Do you utilize pharmacy company "free" medication programs for your patients?
   Yes ___ Approximate yearly dollar value? _____
   No ___
4. Who do you use as a resource for pharmacy questions or concerns?

I. Laboratory Services

1. Do you provide lab tests beyond the 6 required for your RHC designation?
   Yes ___
   No ___
2. Where do you send your patients for lab tests you do not do?
   _____
3. Do you utilize a courier or other service to deliver lab specimens?
   Yes ___
   No ___
4. How do you receive lab reports of results?
   Fax ____
   Electronically ___
   Telephone ___
   Mail ___
   Other ___

J. Radiology and Imaging Services

1. Do you provide radiology or imaging services within the clinic?
   Yes ___
   No ___
2. Where do you send your patients for radiology and imaging services you do not do?
   _____
3. Who reads your x-ray films and studies? _____

4. How do you receive reports of results?
   Fax ____
   Electronically ___
   Telephone ___
   Mail ___
   Other ___

K. Other Practitioners

1. How many days per month do you have other health care professionals (specialists) using space in your clinic? ____
2. Are visiting practitioners charged for the use of space in your clinic?
   Yes ___
   No ___
3. Do you provide staff and/or supplies to visiting practitioners?
   Yes ___
   No ___

L. Electronic Communications

1. Where is the closest place you can go for Telehealth meetings or education?
2. During the last year, have you or your staff taken part in an activity that was held electronically?
   Yes ___
   No ___
3. a) Do you have access to the Internet at work?
   Yes ___
   No ___
   b) At home?
   Yes ___
   No ___
4. What do you use the internet for?
   a) Drug information and interactions ___
   b) Patient information ___
   c) Specific disease information ___
   d) Library searches ___
   e) Other ____ *List* _____
5. a) Do you have email?
   Yes ___
   No ___
   b) What is your email address? *(Is this a private address?)*
   _____ Private? ____

M. Technical Assistance and Training

1. What kind of education or training do you think you or your clinic staff need?
   HIPAA ___
   Billing ___
   Coding ___
   Pharmacy ___
   Office Management ___
   Cultural Competency ___
   Bio-terrorism ___
   Immunizations ___
   Other _____
2. a) Are you a member of the Washington Rural Health Clinic Association?
   Yes ___
   No ___
   If no, Why? _____

   b) The National Rural Health Clinic Association?
   Yes ___
   No ___
   If no, Why? _____
3. Have you attended any of the WRHCA educational offerings?
   Yes ___
   No ___
   If no, Why? _____
4. a) Are you a member of the Washington Rural Health Association?
   Yes ___
   No ___
   If no, Why? _____
   b) The National Rural Health Association?
   Yes ___
   No ___
   If no, Why? _____
5. Are you a member of the RURALHEALTHWA listserve of the Statewide Office of Rural Health? *(Get email address if they would like to be.)*
   Yes ___
   No ___
   If no, Why? _____

(Take brochures for WRHA, WRHCA and RURALHEALTHWA)

N. Other

1. Has the RHC program improved stability of your clinic?

0 5 10

Not at all Moderate A Great Deal

2. Has the RCH program resulted in changes to the number and type pf patients you serve?

   Yes ___
   No ___

   b) *If yes*, describe your sense of how the RHC certification has changed your mix of patients.

   i. Medicare:

Fewer		Same		More
1	2	3	4	5

   ii. Medicaid

Fewer		Same		More
1	2	3	4	5

   iii. Commercial

Fewer		Same		More
1	2	3	4	5

   iv. Uninsured

Fewer		Same		More
1	2	3	4	5

3. Has the RHC program improved the financial performance of your clinic?

0	5	10
Significantly worsened	The Same	A great deal of improvement

4. Has the RHC program or any spin-off from it changed the range of services you provide?

0	5	10
Significantly Reduced	No Change	Significantly changed

5. Has the RHC program changed your ability to recruit MDs?

   Yes ___
   No ___

6. Has the RHC program changed your ability to recruit mid-levels?

   Yes ___
   No ___

7. Has the RHC program affected your way of serving the uninsured in your community?

0 5 10

Major decrease in service to underserved | No Change | major increase in service to

In what ways?

_____

8. What do you see as your largest problems or challenges?

9. What do you see as obvious benefits of being a Rural Health Clinic other than the increased reimbursement?

10 What state and federal resources resources/services do you feel are important to the survival of your clinic?

11. Are there any other comments you would like to add?

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Appendix J - Rural Health Legislation

Chronology of Federal Legislation Affecting Rural Health[1]

Year	Legislation	Rural Provisions
1946	Hospital Survey and Construction Act	Funding for capital expenses
1970	National Health Service Corps	Financial assistance for health care professionals locating in shortage areas
1974	Health Planning and Resources Development Act	Certificate-of-need program created and provided funding for regional health systems agencies.
1976	Health Professions Education Assistance Act	Funding for health professions training
1977	*Rural Health Clinic Services Act (not included in this chronology)*	*Established cost-based funding and midlevel reimbursement in underserved rural areas*
1982	Tax Equalization and Fiscal Responsibility Act (TEFRA)	Established prospective payment system to pay for inpatient services for Medicare
1995	Health Insurance Portability and Affordability Act (HIPPA)	Allowed for creating purchasing cooperatives for health insurance; requires offering continuous insurance coverage to persons changing jobs.
1997	Balanced Budget Act (BBA)	Created the Medicare Rural Hospital Flexibility Program (Critical Access Hospitals); reduced expenditures in the Medicare program; created the State Child Health Insurance Program (SCHIP); created the Medicare+Choice Program
1999	Medicare, Medicaid, and SCHIP BBA Refinement Act	Modified the Hospital Flexibility Program; reduced size of expenditure reductions; modified the Medicare+Choice program.

[1] Handbook of Rural Health, edited by Sana Loue and Beth E. Quill, 2001 Kluwer Academic Plenum Publishers, New York, p.2.

Appendix K - Legislative Changes

Rural Health Clinic Congressional Changes[2]

Date	Legislation	Legislative Description / Amendments
1977	PL 95-210	Rural Health Clinic Services Act PL 95-210- amended Title XVIII, Medicare, of the Social Security Act to provide coverage for RHC services under Part B of Medicare, and amended Title XIX, Medicaid, of the Social Security Act to require that state Medicaid plans provide reimbursements for rural health clinic service. became effective for Medicare on 3/1/78 and for Medicaid on 7/1/78.
1987	OBRA	Amended: ▪ to increase the reimbursement cap for independent RHC to $46 and to mandate its adjustment annually based on the Medicare Economic Index (MEI); and ▪ to make the services of clinical psychologists reimbursable.
1989	OBRA	Amended: ▪ to reduce the percentage of time a nurse practitioner, physician assistant, or certified nurse midwife must be on duty when the RHC is open from 60 to 50%; ▪ added certified nurse midwives as acceptable midlevel practitioners in meeting eligibility requirements for the program; ▪ gave governors the option of designating health services shortage areas (with the consensus of the secretary of the U.S. Department of Health and Human Services) for purposes of the Rural Health Clinics Services Act; and ▪ added clinical social work services to those reimbursed under the Act.
1990	OBRA	Amended: ▪ to expedite the rural health clinic certification process; ▪ allowing certified rural health clinics to temporarily waive the nurse practitioner, physician assistant, or certified nurse midwife requirement if they have lost their NP, PA, or CNM or are having recruiting difficulties; ▪ modified the productivity guidelines for independent RHCs to include the combined services of physicians and NPs, PAs, and/or CNMs; and ▪ clarified the Provider Reimbursement Review Board appeal process for cost requests.
1997	BBA[3]	Amended: ▪ to extend the independent RHC all-inclusive payment methodology & annual payment limit to provider-based RHCs with 50 beds or more. ▪ mandated to conduct quality of care assessments and performance reviews.

2 Rural Health Clinics, A Guide Book for the Dakotas, April 1994
3 Balanced Budget Act, 1997. Rural Policy Research Institute Analysis, July 29, 1999.

Date	Legislation	Legislative Description / Amendments
2000	BIPA[4]	Amended: ▪ to change state Medicaid cost-based reimbursement to a PPS system or alternative payment methodology. ▪ to increase the Medicare reimbursement cap for independent RHC to $63.14, based on the annual Medicare Economic Index (MEI).
2002	Health Care Safety net Amendments[5]	Amended: ▪ allows RHCs to receive automatic HPSA designation if they agree to provide services to all individuals, specifically creating a sliding fee scale for the uninsured.

[4] Benefits Improvement and Protection Act (BIPA) of 2000, section 702, Prospective Payment System for FQHCs and RHCs, Questions and Answers - Handout from Rural Health Clinic Association of Washington Conference, May 15-16, 2003.
[5] Email legislative Update - Bill Finnefrock, Executive Director, National Association of Rural Health Clinics.

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